Report Prepared By

Actuarial Services & Financial Modeling, Inc.

As Requested By

Anthem Blue Cross Life and Health Insurance Company

Regarding

Individual Rates to be Filed with the California Department of Insurance For Non-Grandfathered Health Care Plans with Effective Dates of May 1, 2012 and July 1, 2012

Report Dated: November 12, 2011

By:

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I. EXECUTIVE SUMMARY

Actuarial Modeling ("ActMod") cautions the reader of this Executive Summary of the need to review the complete Report including Attachments to appreciate its purpose, scope, and limitations. This Executive Summary is provided as a convenience to the reader to summarize the key conclusions that are discussed in detail in the body of this Report. The key conclusions are as follows:

A. That, in ActMod's opinion, Anthem applied actuarial sound practices in selecting its methodologies and used reasonable assumptions to develop the rates filed with this Rate Filing. It is also ActMod's opinion that the benefits provided are reasonable in relation to the premiums filed by Anthem for the Benefit Plans impacted by this Rate Filing.

B. That the average rate increase for the Products impacted by this Rate Filing is 9.6% and ranges from a negative 25.4% to a positive 29.9% (i.e. Anthem capped the maximum increase at 29.9%; see Section V. D. for a description).

C. That the rates proposed in this Rate Filing comply with the California Code of Regulations 2222.12 (the "California Code"), are reasonable, and actuarially sound. Specifically, the Future and Lifetime Loss Ratios for the Products impacted by the Rate Filing are substantially in excess of the 70% minimum requirement.

D. That, to the best of our ability, ActMod prepared this Report in compliance with all of the provisions promulgated by the California Department of Insurance regarding Guidelines for compliance with Senate Bill 1163.

E. That Anthem, using sound actuarial practices, projected a calendar year 2012 Medical Loss Ratio in compliance with Accountable Care Act ("ACA") definitions for all individual health care plans underwritten by Anthem. The projected 2012 Medical Loss Ratio exceeds the 80% minimum Medical Loss Ratio promulgated by the ACA.

II. GENERAL BACKGROUND AND SCOPE OF SERVICES

Actuarial Services & Financial Modeling, Inc. [dba Actuarial Modeling ("ActMod")] was engaged to assist the Anthem Blue Cross Life and Health Insurance Company ("Anthem"), by providing an actuarial review of certain individual health insurance rates developed by Anthem and filed with the California Department of Insurance ("CDI").

Anthem is an affiliate of a large complex organization with overarching business plans and objectives. The scope of ActMod's assignment was limited to the review of the health insurance rates developed by Anthem that were included in the rate filing (the "Rate Filing") that is the subject of this report (the "Report"). This included our conducting an independent review of the actuarial methodologies and assumptions used by Anthem to establish the rates in the Rate Filing.

Consistent with ActMod's understanding of typical rate filing reviews by external actuaries, the scope of our engagement did not include a review of Anthem's surplus condition. This is not something that ActMod, nor do we believe other external actuarial consultants, would typically review in the context of a single rate filing. Additionally, we do not consider it necessary or an integral part of the rate filing review process.

In addition to an independent review of the actuarial methodologies and assumptions used by Anthem to prepare this Rate Filing, our scope included a review of the supporting Actuarial Memorandum certified by Fritz Busch of Anthem. We have included a copy of an excerpt of the Actuarial Memorandum (the "Actuarial Memo Excerpt") as Attachment 8 to this Report (the excerpt is complete with the exception that it excludes the Appendix that describes the benefits provided by the various benefit plans impacted by this Rate Filing). Mr. Busch, "Staff Vice President III Individual" with Anthem, is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

The Products impacted by this Rate Filing consist of benefit plans sold on or after the March 23, 2010 effective date of the Accountable Care Act ("ACA") and are referred to as Non-Grandfathered Benefit Plans ("NGF Benefit Plans"). NGF Benefit Plans were required to offer the ACA-mandated benefits effective on the later of September 23, 2010 (i.e. six-months after the ACA effective date) and the next rate change date for the benefit plan.

By September 23, 2010, Anthem had sufficient time to design the most appropriate ACA-compliant benefit plans. Accordingly, Anthem closed to new Members the benefit plans sold during the bridge period between March 23, 2010 and September 23, 2010. This Report refers to these closed benefit plans as the Closed NGF Benefit Plans.

This Report refers to the benefit plans currently available to new Members (i.e. benefit plans sold on or after September 23, 2010) as the Open NGF Benefit Plans.

The Closed NGF Benefit Plans affected by this Rate Filing consist of the twenty-nine benefit plans listed in the Actuarial Memo Excerpt as Attachment 8(a). The Open NGF Benefit Plans affected by this Rate Filing consist of the nine benefit plans listed in the Actuarial Memo Excerpt as Attachment 8(b).

For rate development illustration purposes, the twenty-nine Closed NGF Benefit Plans benefit plans have been consolidated into the twelve Products named in Attachments 14(a) and 14(b) with the prefix "C" in the Product name. Anthem prepared the rates for the Closed NGF Benefit Plans assuming an initial effective date of July 2012 with staggered rate changes by Subscriber renewal month through June 2013.

For rate development illustration purposes, the nine Open NGF Benefit Plans benefit plans have been consolidated into the eight Products named in Attachments 14(c) and 14(d) with the prefix "O" in the Product name. Anthem prepared the rates for the Open NGF Benefit Plans assuming an initial effective date of May 2012 with staggered rate changes by Subscriber renewal month through April 2013.

This Report, our actuarial analysis, and our actuarial opinions are based on these assumed effective dates and staggered rate change months. We understand, however, that actual rate changes are, on occasion, delayed due to the regulatory rate filing process. Should the assumed effective date for the rate changes be delayed with no offsetting trend adjustment, the adverse impact on the actuarial soundness for the projection period is not reflected in this Report.

ActMod was also asked to prepare this Report to address the actuarial certification requirements described in CDI Guidance 1163:2 released April 5, 2011 regarding rate filing requirements for compliance with Senate Bill 1163 ("SB 1163 Guidance") with respect to our independent review of the Rate Filing.

Please note that throughout this Report the definition of capitalized terms can generally be found in Attachment 3 ("Definitions and Industry Terminology").

III. SUMMARY OF METHODOLOGIES USED FOR THE RATE FILING

Anthem constructed and followed several key methodologies that were used in the preparation of the Rate Filing. A summary description, followed by a detailed review, of each such methodology follows:

A. **Gathering of Detailed Data**: The first step in preparing a Rate Filing is to capture the relevant data at the appropriate level of detail to support the analysis required. Anthem captured substantial information for Membership, Premiums, Claims, and related information (e.g. data by Policy Duration, historical rate change information, Benefit Plan information, Lapse Rate data, and Member Anniversary Months).

B. **Medical Trend Analysis**: Since the Products impacted by this Rate Filing are relatively immature (i.e. effective dates of March 2010 and later), Anthem analyzed Medical Trends for these Products in conjunction with the experience data of the more mature predecessor Grandfathered Benefit Plans that most closely correlated with those impacted by this Rate Filing. The Medical Trend analysis is included in the Rate Filing filed with the CDI for these Grandfathered Benefit Plans at the same time this Rate Filing was submitted for review (the "GF Benefit Plan Rate Filing").

   Medical Trends are used to project medical costs from the Experience Period to the Rating Period. Medical Trend assumptions are also required to project the Future and Lifetime MLRs required to comply with the California Code of Regulations 2222.12 (the "California Code").

C. **Benefit Plan Relativity Analysis**: Anthem prepared detailed claims and premium benefit relativity factors by benefit plan for each Product impacted by the Rate Filing. Corresponding membership was also captured and evaluated. The member-weighted benefit plan relativities for claims are used to normalize "Plan Mix" for the historical months used for the Medical Trend analysis. The Plan Mix adjustment for the historical months used by Anthem's Lifetime Medical Loss Ratio Model (the "LLR Model") adjusts the benefit plan relativities for claims and the adverse selection impact on premiums attributable to individual Subscriber benefit selections. The LLR Model is used for rate development and to demonstrate compliance with the California Code's minimum lifetime loss ratio requirement.

D. **Claim and Premium Durational Analysis**: Anthem used credible data to develop both Claim Durational and Premium Durational Factors for the Products impacted by the Rate Filing. The Claim Durational Factors were used to adjust and analyze historical experience for developing the Medical Trend assumptions. Both Premium and Claim Durational Factors are used by Anthem's LLR Model.

E. **Medical Trend Leverage Analysis**: Anthem evaluated and reflected Product-specific Medical Trend Leverage Factors in the development of the Medical Trend estimates used by the LLR Model.

F. **Seasonality Factor Analysis**: Anthem prepared an analysis of the impact that Seasonality would have on monthly experience throughout a calendar year for each Product. The Seasonality analysis is used by the LLR Model, which captures historical and projects claims experience on a month-by-month basis.

G. **Evaluation of Benefit Plan Changes**: The Rate Filing reflected benefit changes for:

(1) Previously filed benefit revisions (Note: previously filed benefit revisions must be considered to the extent they impact the Experience Period and/or the Rating Period used for the current Rate Filing.):

(a) Benefit revisions mandated by the ACA (e.g. elimination of Lifetime Benefit limitations, covering Preventive Services with no Member cost sharing, and Guaranteed Issue rights for Children) were previously filed with the CDI.

(b) Benefit revisions other than those mandated by the ACA previously filed with the CDI (e.g. proposed increases in Benefit Plan deductibles and coinsurance maximums, also referred to as out-of-pocket maximums).

(2) A California State mandate effective July 1, 2012 that all benefit plans cover maternity medical costs.

(3) A California State mandate effective July 1, 2012 that all benefit plans cover certain autism medical costs.

The potential cost impact of Benefit Plan changes must be considered to properly reflect projected claims costs for the Rating Period.

H. **Anniversary Month Analysis**: Anthem carefully captured and projected Members by Renewal or Anniversary Month for each Product. The Membership distribution by Anniversary Month is important when estimating premium dollars for the Rating Period and when normalizing historical data for historical rate changes. Accordingly, the distribution by Anniversary Months is used by the LLR Model.

I. **Lapse Rate Analysis:** Anthem prepared a detailed analysis of Lapse Rates for the following three Product categories:

(1) Monthly Lapse Rates for the Basic Hospital Plans Product.

(2) Monthly Lapse Rates for "Standard PPO" Products (i.e. SmartSense, PPO Share, Right Plan, Tonik, Lumenos w/ Maternity, PPO Saver, Premium, ClearProtection, and CoreGuard).

(3) Monthly Lapse Rates for the Individual PPO Plans and Lumenos w/o Maternity Products.

J. **Establishing a Rate Development Process**: Once Anthem captured and completed the required backup analysis, they applied what is often referred to as a "Rate Development Process". Anthem developed and followed a detailed Rate Development process to determine and evaluate the rate changes proposed in the Rate Filing. In general, the Rate Development process begins with data summarized for the Experience Period and applies the appropriate adjustments (i.e. the items described above in this Section of the Report) to project the relevant parameters to the Rating Period, which includes the proposed rate changes. The Rate Development Process has been incorporated into and is an integral component of Anthem's LLR Model.

K. **Preparing and Analyzing the LLR Model**: One of the critical steps for the Rate Filing involved populating and analyzing Anthem's LLR Model with the information noted above in this Section of the Report. The LLR Model develops the Future and Lifetime Medical MLRs that are used to demonstrate compliance with the California Code's minimum lifetime loss ratio requirement.

L. **Capture and Analyze the Reporting Requirements of SB 1163 Guidance:** The final step for the purpose of preparing this Report involved capturing and documenting the various requirements of the SB 1163 Guidance.

IV. Details of Methodologies Used for the Rate Filing

Following is a detailed description of the process used by and the opinions reached by ActMod for each of the items summarized in Sections III. A. through L. above.

A. **Gathering of Detailed Data**: Anthem gathered the data necessary to prepare the Rate Filing. The details of the data captured and used are described in the below discussion of the various methodologies.

For the Closed NGF Benefit Plans, the Rate Filing assumes rate change dates for the twelve renewal months from July 2012 through June 2013, inclusive. For the Open NGF Benefit Plans, the Rate Filing assumes rate change dates for the twelve renewal months from May 2012 through April 2013, inclusive.

Anthem selected a data period consistent with the time required to prepare and submit the Rate Filing to the appropriate regulatory authorities with sufficient time for adequate regulatory review. Specifically, Member, claims payment and premium data was available through August 31, 2011.

Since claim incurral analysis requires a review of claims payments made beyond the actual date of incurral, Anthem used the claim incurrals through June 30, 2011 with claim payments through August 31, 2011 for the Rate Development process.

ActMod believes that the data and time periods used by Anthem to prepare this Rate Filing is consistent with sound actuarial practices and principles.

B. **Medical Trend Analysis**: Medical Trend Factors are critical to the development of actuarially sound projections for medical costs and medical loss ratios.

(1) **Underlying Medical Trends (excluding Medical Trend Leverage)** : As previously noted, Anthem relied on the Medical Trend analysis and experience described in the GF Benefit Plan Rate Filing to establish the Medical Trend assumptions for this Rate Filing. This provided Anthem with an actuarially sound estimate for the underlying Medical Trend exclusive of the impact of Medical Trend Leveraging.

(2) **Medical Trend Leverage Analysis:** Anthem next applied the same methodology described in the GF Benefit Plan Rate Filing to develop Product-specific Medical Trend Leverage factors for the Products impacted by this Rate Filing.

(3) **Medical Trend with Medical Trend Leverage**: The final step involved applying the Product-specific Medical Trend Leverage Factors from Step (2) above to the Underlying Medical Trends from Step (1) above. The results of the analysis are summarized in Attachments 9(a) and 9(b) for the Closed NGF Benefit Plans and the Open NGF Benefit Plans, respectively.

(a) Column (1) shows the Underlying Medical Trend without Medical Leverage.

(b) Column (2) shows the Medical Trend Leveraging Factor for each Product.

(c) Column (3) develops Product-specific Medical Trends by multiplying the Underlying Medical Trend by the Product-specific Medical Trend Leveraging Factors.

ActMod conducted a detailed review of Anthem's methodologies and assumptions with respect to the Medical Trend Factors and believe they are actuarially sound and the assumptions reasonable.

C. **Benefit Plan Relativity Analysis**: Anthem developed benefit plan relativities to appropriately adjust for movement across benefit plans within a defined Product. Benefit plan relativities were used for both the Medical Trend analysis and for the projections developed by the LLR Model.

ActMod reviewed the benefit plan claim relativity factors for directional reasonableness and found them to be reasonable. For the detailed factor analysis, we relied on the analysis performed by the Anthem actuary identified in the Actuarial Reliance Certification (Attachment 2).

D. **Claim and Premium Durational Analysis:** Claim Durational Factors are used both for the Medical Trend Analysis and the LLR Model. The Product-specific Premium and Claim Durational Factors used for this Rate Filing have been updated with more recent data. For the prior rate filing (i.e. 2011 filing #PF-2011-00002), the Premium and Claim Durational Factors were based on calendar year 2008 data with claims paid through September 2009. This Rate Filing uses calendar year 2010 data with claims paid through February 2011. The methodology used is identical to that used for the prior rate filing with the only exception being that for this Rate Filing a more exacting mathematical formula was used to smooth the raw calculations for the Premium and Claim Durational Factors:

The Claim Durational Factors are shown in the Actuarial Memo Excerpt as Attachments 8(e) and 8(i) for the Closed NGF Benefit Plans and the Open NGF Benefit Plans, respectively.

While not used for Medical Trend analysis, the Premium Durational Factors are calculated in conjunction with the Claim Durational Factors. The Premium Durational Factors are used by the LLR Model and are shown in the Actuarial Memo Excerpt as Attachment 8(f) and 8(j) for the Closed NGF Benefit Plans and the Open NGF Benefit Plans, respectively.

In addition to reviewing Anthem's detailed analysis of the Durational Factors and the methodology used, ActMod also reviewed the results for reasonableness and found them to be reasonable. For our reasonability review, we prepared Attachments 10(a) and 10(b) that shows the Medical Loss Ratios ("MLR's") by Duration for the Closed NGF Benefit Plans and the Open NGF Benefit Plans, respectively. The MLR's, as expected, are relatively low for the initial durations and generally increase for the subsequent durations. The exceptions, again as expected, are the plans that cover maternity (i.e. PPO Share and Lumenos w/ Maternity). For plans covering maternity the adverse selection attributable to paying maternity claims during the first year of coverage is evident. The MLR for plans covering maternity increase rapidly during the first year with the Quarter 4 MLR exceeding 100%; the MLRs then actually decrease for durations 2 through 6 before increasing for the longest durations.

In ActMod's opinion, the methodology, the analysis, and the resulting Durational MLRs are all consistent with Anthem having applied sound actuarial practices and principles in the development of the Premium and Claim Durational Factors.

E. **Seasonality Factor Analysis** – Seasonality can be an important consideration with respect to establishing the initial and subsequent monthly assumptions for Anthem's LLR Model. Anthem developed its Seasonality Factors as follows:

(1) Anthem reviewed month-by-month Product-specific seasonality factors for the 12-month period ending May 2011.

(2) Anthem appropriately adjusted the month-by-month Product-specific PMPMs for Medical Trends to avoid having Medical Trends distort the seasonality analysis.

(3) Anthem conducted the analysis independently for medical costs and prescription drug costs. The results were composited to develop aggregate Product-specific seasonality factors for medical and prescription drug costs combined.

(4) Anthem next reviewed Product-specific characteristics that would most likely impact the seasonality factors (e.g. calendar year deductibles generally have the greatest impact on seasonality with high deductible plans experiencing a disproportionate proportion of the total annual claims in the latter half of each calendar year). Following this review, Anthem combined the claims experience for like Products to develop seasonality factors for specific Product groupings.

The resulting Product-specific seasonality factors for each the Closed NGF Benefit Plans and the Open NGF Benefit Plans are shown in Attachments 11(a) and 11(b), respectively.

ActMod conducted a detailed review of Anthem's methodologies and assumptions with respect to the Seasonality Factors.

Since seasonality can vary from year-to-year, ActMod tested the stability of the factors by applying the identical methodology as that used by Anthem (with the exception that for simplicity we evaluated only medical claims without prescription drugs) to the 12-month period ending May 2010 (i.e. the 12-month period that immediately preceded the May 2011 period chosen by Anthem). Our analysis resulted in a slight flattening of the seasonality factors for the fourth quarter of the calendar year. We used this second set of factors in Anthem's LLR Model to test for sensitivity. The result was an indicated average rate increase for all Products impacted by this Rate Filing that were approximately 1.5% greater than that based on Anthem's assumed seasonality factors. Assuming theoretical accuracy somewhere between the results produced by Anthem's seasonality factors and ActMod's test factors, we concluded that the filed results are within a reasonable range of what can be considered actuarial uncertainty.

In conclusion, we believe Anthem's methodology with respect to developing Seasonality Factors is actuarially sound and the assumptions reasonable.

F. **Evaluation of Benefit Plan Changes:** The Rate Filing considers the following benefit changes:

(1) ACA-mandated benefits: The rate changes required to provide the ACA-mandated benefits for the Products impacted by this Rate Filing have already been placed on file with the CDI (please refer to the 2011 filing #PF-2011-00002).

For this current Rate Filing, Anthem appropriately reflected the impact on historical and projected premium and claim experience used for the Rate Development process. The impact is shown in Column (1) of Attachments 12(a) and 12(b) for the Closed NGF Benefit Plans and the Open NGF Benefit Plans, respectively.

(2) Prior Filed Benefit Changes: As noted for the above-noted ACA-mandated benefit revisions, the rate changes required for these non-mandated benefit changes were also placed on file with the CDI in the 2011 filing #PF-2011-00002.

For this current Rate Filing, Anthem appropriately reflected the impact on historical and projected premium and claim experience used for the Rate Development process. The impact is shown in Column (2) of Attachments 12(a) and 12(b) for the Closed NGF Benefit Plans and the Open NGF Benefit Plans, respectively.

(3) Mandated Maternity Benefits: Effective July 1, 2012, California Law mandates that maternity be a covered benefit. Currently, only the PPO Share and Lumenos w/ Maternity Products cover maternity.

Anthem assumed that once all Products begin offering maternity benefits that a portion of the maternity costs currently incurred by the PPO Share and Lumenos w/ Maternity Products would be borne by the other Products. Accordingly, this Rate Filing includes a benefit credit of 2.5% for each the Closed and Open NGF PPO Share and Lumenos w/ Maternity Benefit Plans.

For the remaining Closed NGF Benefit Plans, this Rate Filing assumes that covering maternity will increase medical benefit costs by 2.0%. For the remaining Open NGF Benefit Plans, this Rate Filing assumes that covering maternity will increase medical benefit costs by 5.0%. The differential in costs is attributable to the fact that a Subscriber may opt to apply for an open plan covering maternity but may not opt to apply for a closed benefit plan. Accordingly, it is reasonable to assume that substantially more maternity claims will be paid by the Open NGF Benefit Plans.

The 2.5% benefit credits and the corresponding 2.0% and 5.0% benefit increases are shown in Column (3) of Attachments 12(a) and 12(b) for the Closed NGF Benefit Plans and the Open NGF Benefit Plans, respectively.

ActMod reviewed the methodology and assumptions used by Anthem in determining the maternity credit and cost assumptions and believe they are reasonable but may understate the ultimate cost. We base this opinion on our independent analysis of maternity costs. ActMod's proprietary pricing model suggests that maternity costs can be expected to amount to 8% of total medical costs for a population not subject to Adverse Selection. We concur with Anthem's assumption that they will not be subjected to the full impact of maternity costs since two Benefit Plans already cover maternity. Again, while reasonable, we believe the rate adjustments proposed by Anthem may prove to be somewhat deficient and may modestly understate the required rate change for this mandated benefit.

(4) Mandated Autism Benefits: Effective July 1, 2012, California Law mandates coverage for certain autism-related medical costs. Anthem prepared and ActMod reviewed a detailed analysis of the expected costs attributable to this mandated benefit. Specifically, Anthem considered the unit costs and utilization attributable to the following medical services related to autism:

(a) Applied Behavior Analysis ("ABA") Services

(b) Physical Therapy / Occupational Therapy / Speech Therapy ("PT/OT/ST") Services

Anthem concluded and ActMod concurs that a reasonable cost estimate for this mandated Autism benefit is 0.6% of medical costs. This factor is shown in Column (4) of Attachments 12(a) and 12(b) for the Closed NGF Benefit Plans and the Open NGF Benefit Plans, respectively.

In conclusion, ActMod reviewed the analyses prepared by Anthem regarding the pricing of the above-noted benefit revisions and, in our opinion, the methodologies employed followed sound actuarial principles and the assumptions are reasonable. The individual benefit revision impacts by Product are shown in Columns (1) through (4) of Attachments 12(a) and 12(b). Columns (5) through (7) show the following:

(i) Gross Impact in Column (5): This shows the composite impact of the benefit revisions shown in Columns (1) through (4) without regard to the actual months that impact the Rate Development process.

(ii) Experience Period Impact in Column (6): This column weights the month-by-month benefit revision impacts during the Experience Period by the corresponding Membership and PMPM impacts.

(iii) Rating Period Impact in Column (7): This column weights the month-by-month benefit revision impacts during the Rating Period by the corresponding Membership and PMPM impacts.

E. **Anniversary Month Analysis** – Properly reflecting rate change anniversary months for this Rate Filing required that careful attention be paid to the actual Subscriber rate change dates. The Rate Development Process for this Rate Filing assumes that the rate changes proposed would occur the later of 6 months since a Subscriber's prior rate change date and the initial effective dates of May 1, 2012 and July 1, 2012 for the Open NGF Benefit Plans and Closed NGF Benefit Plans, respectively.

For example, Members enrolled in an Open NGF Benefit Plan who receive an increase in December 2011 would receive the increase proposed in this Rate Filing on June 1, 2012 and June would become the new Anniversary Month for these Members. Once all Members passed through this one-time six month cycle, the Rate Filing assumes that all Members will revert to receiving their increases every 12 months.

Of course, to the extent Members had contractual rate guarantees, such guarantees would be honored by Anthem.

The expected effective dates for the rate changes and the Member distribution for the Closed NGF Benefit Plans and the Open NGF Benefit Plans are shown in the Actuarial Memo Excerpt as Attachments 8(f) and 8(j), respectively.

Anthem carefully considered the impact on Anniversary Months and, in our opinion, reflected the impact in an actuarially sound manner.

F. **Lapse Rate Analysis**: Anthem used a study based on Member lapse rates for the months of January 2010 through January 2011 for Policy Duration months 1 through 73 or later. The results of the study are displayed in Attachment 13. As noted in the box in Attachment 13(a), the lapse rate assumptions by Policy Duration month are grouped by Product as follows:

(1) **The Basic Hospital Product**

(2) **The Standard PPO Products**: SmartSense, PPO Share, Right Plan, Tonik, Lumenos w/ Maternity, PPO Saver, Premium, ClearProtection, and CoreGuard

(3) **The High Deductible PPO Products**: Individual PPO Plans and Lumenos w/o Maternity

The lapse rates shown in Attachment 13 were reduced by 20% and used by the LLR Model for the Closed NGF Benefit Plans impacted by this Rate Filing. Anthem indicated that they applied this 20% reduction factor for the Closed NGF Benefit Plans since the impacted Subscribers elected to retain their existing coverage after being offered the opportunity to transfer their coverage to comparable Open Non-Grandfathered Products with no underwriting requirements. That is, Anthem assumed that the impacted Subscribers prefer their existing coverage and are less likely to lapse their policies. ActMod concurs that this is a reasonable assumption. We also understand that Anthem will continually monitor ongoing lapse rates and adjust them as experience evolves.

ActMod conducted a detailed review of Anthem's methodologies and assumptions with respect to the Lapse Rate Analysis and believe they are actuarially sound and the assumptions reasonable.

G. **Geographic Area Factor Changes**: For this Rate Filing, Anthem reviewed and realigned the Geographic Area Rating Factors to make them more representative of underlying medical costs. Anthem based the realignment on data for the 2010 calendar year. ActMod reviewed Anthem's analysis to verify that the proposed Area Rating Factors could be expected to be revenue neutral when compared to the revenue generated by the current Area Rating Factors. We concluded that the proposed Area Rating Factors were revenue neutral for the study period.

In ActMod's opinion, Anthem followed sound actuarial principles and developed actuarially sound Geographic Area Factors that can be expected to be revenue neutral. The "Old" and "New" Geographic Areas are shown in the Actuarial Memo Excerpt as Attachment 8(c).

H. **Establishing a Rate Development Process**: A Rate Development Process involves the integration of many of the assumptions discussed in Sections IV. A. through G. above into a comprehensive analysis that progresses from the summary of basic data for a defined Base Period through the development of actual premium rates, required rate changes, and/or proposed rate changes.

Anthem selected the time periods July 1, 2010 through June 30, 2011 as the Base Period. The Rating Periods used covered the 12-month renewal months for the month beginning May 2012 for the Open NGF Benefit Plans and July 2012 for the Closed NGF Benefit Plans. The steps Anthem followed for this Rate Filing are shown on Attachments 14(a) through 14(d) and consist of the following [note the below numbered sections correspond to the numbered rows on Attachments 14(a) through 14(d)]:

BASE PERIOD ANALYSIS

(1) Member months; are captured for the Base Period.

(2) Actual Premium; are captured for the Base Period.

(3) Estimated Incurred Claims; are captured for the Base Period (Note: "Incurred Claims" are always considered estimates since they always include some estimate for claims incurred but not yet paid – even if that estimate is zero). Anthem used a two-month run-out period for incurred claims to ensure their credibility (i.e. paid claims through August 31, 2011).

(4) Current Loss Ratio = Step (3) / (2)

(5) Current Claims PMPM = Step (3) / (1)

(6) Credibility Adjusted Claims PMPM; Anthem used the following standard industry formula for credibility:

Credibility = (MM / 60,000)^(0.5)

Where: MM = Member Months for Base Period

Credibility = 100% for MM greater than 60,000

We note that the above formula is standard but the 60,000 Member Month parameter for 100% credibility varies by company and purpose. In ActMod's opinion, 60,000 is a reasonable assumption for 100% credibility for rating individually underwritten health care policies.

Since most of the Products impacted by this Rate Filing are relatively immature, most of the Products were deemed to be less than 100% credible as noted by the shading in this Row 6 of Attachment 14. In general, Anthem used the Base Period data for the most comparable Closed Grandfathered Product for the non-credible portion of the Base Period Claims.

In ActMod's opinion, Anthem's methodology used for credibility followed actuarial sound principles and the assumptions are reasonable. We also concur with the selections Anthem made regarding the non-credible portion of the Base Period Claims.

(7) Midpoint of Base Period; this is calculated as the Member-weighted midpoint of the Base Period.

PREMIUM AT CURRENT RATES

(8) Prem at Current Rates PMPM; these PMPMs adjust the Actual Base Period Premium for current rates, the Premium Durational Factors, and the Plan Mix Premium Factors.

MEDICAL TREND ANALYSIS

(9) Annual Claims Trend; this item includes the Product-specific Medical Trends shown in Attachment 9 that were described in Section IV. B. above. The LLR Model used these annualized Medical Trends for the duration of the projection period (i.e. through December 2025).

(10) Initial Rate Change Date; this is the first month a Subscriber will receive the filed rate changes (i.e. May 2012 for Open NGF Benefit Plan renewals and July 2012 for Closed NGF Benefit Plan renewals).

(11) Midpoint of Rating Period; this is calculated by weighting the Member Months during the Rating Period with the proportion of Members projected to receive the proposed rate change for each month during the Rating Period.

(12) Months of Trend; this is calculated as the number of months between the Midpoint of the Base Period [Step (7)] and the Midpoint of the Rating Period [Step (11)].

(13) Cumulative Trend; this is the total Medical Trend between the Base Period and the Rating Period [i.e. the Annual Claims Trend from Step (9) and the Months of Trend from Step (12)].

RATING PERIOD CLAIMS COST

(14) Change in Plan Mix Factor (Claims); this is the change in the Member-weighted Benefit Relativity Factors for Claims [as discussed in Section IV. C. above] between the Base Period and the Rating Period.

(15) Change in Clms Duration Factor; this is the change in the Member-weighted Claims Duration Factor [see Attachments 8(e) and 8(i) of Actuarial Memo Excerpt for the Closed and Open NGF Benefit Plans, respectively] between the Base Period and the Rating Period.

(16) Change in Seasonality Factor; this is the change in the Member-weighted Seasonality Factors for Claims [see Attachments 11(a) and 11(b) for the Closed and Open NGF Benefit Plans, respectively] between the Base Period and the Rating Period.

(17) Benefit changes: ACA and "Other"; these are the composite benefit change values summarized in Attachments 12(a) and 12(b) for the Closed and Open NGF Benefit Plans, respectively.

(18) Rating Period Claims PMPM; this is calculated by applying the various claim projection factors in Steps (14) through (17) and the Cumulative Trend factor in Step (13) to the Credibility Adjusted Claims PMPM in Step (6).

RATING PERIOD PREMIUMS

(19) Change in Plan Mix Factor (Prem); this is the change in the Member-weighted Benefit Relativity Factors for Premiums discussed in Section III. C. above.

(20) Change in Prem Duration Factor; this is the change in the Member-weighted Premium Duration Factor [see Attachments 8(f) and 8(j) of the Actuarial Memo Excerpt for the Closed and Open NGF Benefit Plans, respectively] between the Base Period and the Rating Period.

(21) Adj'd Prem at Current Rates PMPM; this is calculated by applying the premium adjustment factors in Steps (19) and (20) to the Premium at Current Rates in Step (8).

(22) Target Loss Ratio; this is Anthem's Target Loss Ratio that is essentially established to meet internal financial targets while ensuring compliance with each the California Code and the Accountable Care Act ("ACA").

(23) Required Premium PMPM; the Required PMPM is the premium PMPM required to achieve the Target Loss Ratio. The Required Premium PMPM is calculated by dividing the Rating Period Claims PMPM from Step (18) by the Target Loss Ratio in Step (22).

(24) Required Rate Increase – new business; this is calculated by dividing the Required Premium PMPM in Step (23) by the Adjusted Premium at Current Rates in Step (21).

(25) Proposed Rate Change – new business; virtually all pricing decisions ultimately come down to balancing a series of complex internal and external variables and considerations, including but not limited to the need to maintain sound financial discipline, competitive considerations, and regulatory pressures. The culmination of these considerations is captured in this Step.

(26) Renewal Rate Change; this is the average monthly renewal rate change weighted by the Members renewing by Anniversary Month throughout the Rating Period.

ActMod conducted a detailed review of Anthem's methodologies and assumptions with respect to the Rate Development Process and believe they are actuarially sound and the assumptions reasonable.

I. **Preparing and Analyzing the LLR Model:** the final analytical step to the Rate Development Process involves populating the LLR Model with the various aforementioned data, assumptions, and calculations. This is an iterative process that involves coordinating and integrating the ultimate results from the LLR Model with the ultimate results described in Section IV. H. above for the Rate Development Process.

A separate LLR Model is prepared for each Product impacted by the Rate Filing and in the aggregate across all Products. The primary objective of this exercise is to ensure compliance with the California Code.

The steps involved include:

(1) Develop initial "Starting Points" for normalized Premium PMPMs and Claims PMPMs. The Premium and Claims PMPM are normalized for the various factors described in Section IV. H. for the Rate Development Process (e.g. Premium and Claims Durational Factors, Plan Mix Factors, and Seasonality).

The Starting Point Claims must also be trended to the Starting Point (i.e. July 2011 for the Rate Filing) and Premiums must be adjusted to the Current Rate Basis.

(2) The LLR Model must be populated with month-by-month historical membership, which are projected by applying lapse rates to existing members and, when applicable, new sales assumptions. Of course, for the Closed NGF Benefit Plans new sales assumptions were not required. The lapse assumptions shown in Attachment 13 (reduced by 20% for the Closed NGF Benefit Plans for the reasons cited in Section IV. F. above) were used by the LLR Model.

(3) The LLR Model projects month-by-month membership, premium, and claim information using all of the data, assumptions, and calculations discussed throughout this Report.

(4) The LLR Model projects claims through calendar year 2025 and, accordingly, requires Medical Trend and Rate Change assumptions for this entire duration. The Medical Trends used by Product and in the aggregate across all Products throughout the projection period are shown in Attachment 14, Step 9.

(5) Since the end product of the LLR Model involves present value calculations for Premiums and Claims, a discount rate must be assumed. Anthem used a discount rate of 3.57%, which was the 30 year U.S. Treasury Bond rate in August 2011. ActMod believes this is a reasonable methodology and assumption for the LLR Model.

(6) The Calendar Year by Calendar Year MLR's and the Future and Lifetime LLRs for the Closed NGF Benefit Plans and the Open NGF Benefit Plans are developed by the LLR Model and shown in Attachments 8(m) and 8(n) of the Actuarial Memo Excerpt, respectively. The ratios shown demonstrate compliance with the California Code. In fact, the ratios of 91.9% and 88.4% for the Closed NGF Benefit Plans and 86.6% and 86.2% for the Open NGF Benefit Plans are all substantially above the 70% minimum required by the California Code.

ActMod conducted a detailed review of Anthem's methodologies and assumptions with respect to the LLR Model and believe they are actuarially sound and the assumptions reasonable.

V. SUMMARY OBSERVATIONS AND OPINIONS

A. Compliance with the California Code: The California Code requires that the Future MLR and the Lifetime MLR must each be not less than 70%. The compliance with ACA-defined MLRs is discussed in Section VII.

As noted in Section IV. I. (6) above, the Future and Lifetime MLRs of 91.9% and 88.4% for the Closed NGF Benefit Plans and 86.6% and 86.2% for the Open NGF Benefit Plans are all materially above the 70% minimum required by the California Code.

B. Premium Rate Structure: The Premium Rate Structure employed by Anthem is described in Attachments 8(c) and 8(d) of the Actuarial Memo Excerpt. It is important to recognize that the attained age rating methodology, which is typical in the industry, would result in annual rate changes even in the absence of the proposed rate changes.

The filed average premium rate changes of 9.2% for the Closed NGF Benefit Plans and 9.7% for the Open NGF Benefit Plans are shown in Attachments 8(e) and 8(i) of the Actuarial Memo Excerpt. These rate changes reflect increases above the rates already in place (i.e. the filed premium rate changes exclude the impact of aging).

C. Anniversary Month Impact: Not all Members will receive the rate changes noted in this Report on the initial effective dates of May 1, 2012 and July 1, 2012. Rather, Members will receive the rate change on the later of: (i) July 1, 2012 for the Closed NGF Benefit Plans and May 1, 2012 for the Open NGF Benefit Plans, (ii) the end of any applicable rate guarantee period, or (iii) six months after the Subscriber's previous renewal date.

D. Rate Caps: Anthem has traditionally included Rate Caps in its Rate Filings. That is, the total rate change for a Member, inclusive of Aging and rate changes not received for prior rate change periods is limited to a certain percentage; for this Rate Filing that percentage is 14.9% for the Closed NGF Benefit Plans and 29.9% for the Open NGF Benefit Plans. The impact of rating characteristics other than Aging (i.e. geographic area and family contract type) are not considered in the application of the Rate Cap.

ActMod's analysis concluded that for the above Products impacted by this Rate Filing, the rates developed comply with the California Code, are reasonable, and are actuarially sound.

VI. QUALIFICATIONS, RELIANCES, AND LIMITATIONS

James P. Galasso, President & Consulting Actuary for ActMod, a Fellow in the Society of Actuaries and a Member of the American Academy of Actuaries prepared this Report. Mr. Galasso has over thirty years' experience in actuarial work related to health care, has served as the Chief Actuary and Chief Financial Officer of large managed care organizations, and has provided actuarial consulting services to the health care industry. In these various capacities, Mr. Galasso has addressed the areas discussed in this Report on numerous occasions and meets the Qualification Standards for *Actuaries Issuing Statements of Actuarial Opinion in the United States* to issue the opinions contained herein. Mr. Galasso also meets the independence requirements stated in the California Insurance Code section 10181.6 (b)(3).

Mr. Galasso applied the appropriate actuarial standards in conducting his review of the actuarial methodologies and calculations used by Anthem to prepare the Rate Filing. Mr. Galasso's curriculum vitae can be found as Attachment 1 to this Report.

Various files provided to ActMod by Anthem and discussed in this Report enabled us to reach the opinions presented in this Report. The scope of this engagement included either a detailed independent review of these files or, where noted, reliance on the Reliance Actuary identified in Attachment 2.

The estimates subject to review by this Report, of necessity, are inexact and may include projections of events that have not yet taken place (e.g. claims paid beyond the date for which information was available). While ActMod used accepted actuarial procedures in the review of these estimates, there can be no assurances that the ultimate actual projections will not differ materially from these estimates. While the definition of materiality is not objectively definable, we suggest that the reader of this Report consider as material variances greater than 2% from the projections discussed in this Report. Of course, the definition of materiality may vary based on the intended use by or the perspective of an individual or organization. In addition the accuracy of any estimates reviewed or discussed in this Report are dependent upon the availability and quality of the data received.

The detailed data (i.e. claim records, membership files, and premiums earned) that were required to prepare this Report were accepted as accurate and valid by ActMod without audit or detailed verification. Accordingly, ActMod is not able to provide assurances in this Report concerning the integrity of such information used in our analyses and on which our findings are based.

ActMod did review all data and information provided for general reasonableness. We have no reason to believe that any of the data or information provided is not accurate. Additionally, we believe our review addressed the appropriate issues and our conclusions presented herein are reasonable, given the information provided.

Anthem was able and did provide all of the information requested by ActMod.

The scope of this engagement does not constitute a rendering by ActMod, its employees, or its agents of any legal advice, and because our engagement is limited in nature and scope, it cannot be assumed to provide all analyses that may have importance to Anthem or others in this matter.

Unless legally required to do so, this Report may not be copied, reproduced, or distributed to others at any time without the prior written consent of both ActMod and Anthem. This Report may contain certain nonpublic information, and, accordingly, recipients shall treat this Report, and any nonpublic information made available hereunder, as confidential. Distribution of this Report must be in its entirety, including any Attachments or Appendices.

Nothing included in this Report may be included in any filing with the Securities and Exchange Commission.

Any reader of this Report must possess a substantial level of expertise in areas relevant to this analysis to appreciate the significance of the assumptions used in the analysis, and the impact of the assumptions on the illustrated results.

VII. COMPLIANCE WITH SB 1163 GUIDANCE

The specific requirements of the SB 1163 Guidance are included below in Bold Type in whole or in summary form for the reader's convenience and for reference purposes. The complete copy of the SB 1163 Guidance is included as Attachment 4. ActMod's response regarding compliance is noted immediately below each provision:

Section A: Unreasonable Rate Increases:

1) The relationship of the projected medical loss ratio to the federal medical loss ratio standard in the market segment to which the rate applies, after accounting for any adjustments allowable under federal law.

Attachment 8(o) of the Actuarial Memo Excerpt is a summarization of more detailed Exhibits prepared by Anthem that demonstrates compliance for Calendar Year 2012 with the ACA-defined minimum loss ratio standard of 80% for Individual Health Insurance Policies. Specifically, Attachment 8(o) shows a projected Calendar Year 2012 ACA-defined MLR of 81.24%.

The detailed analysis that ActMod discusses in Sections III and IV of this Report address the Products impacted by the Rate Filing. ActMod also reviewed the detailed assumptions that Anthem used to prepare the projections for its other individual health care product offerings that culminated in the table shown in Attachment 8(o).

In ActMod's opinion, the information summarized in Attachment 8(o) is a reasonable projection of Calendar Year 2012 results for Anthem's individual health care business. The resulting ACA-defined MLR of 81.24% demonstrates compliance with the projected medical loss ratio standard promulgated by ACA.

2) Whether the assumptions on which the rate increase is based are supported by substantial evidence.

As noted throughout this Report, it is ActMod's opinion that Anthem's Rate Filing assumptions are reasonable and supported by substantial and documented evidence. ActMod notes that "substantial" is a subjective non-actuarial term. But for the purposes of this Rate Filing review, ActMod defines substantial as the methodologies and applications of the methodologies that are sufficient for us to reach the actuarial judgments presented throughout this report – including our opinion of the reasonableness of the proposed rate changes. In addition to the methodologies themselves, we also include in the definition of substantial our belief that the data relied upon for the application of the methodologies was credible and adequate for the task. This definition is consistent with the review of this Rate Filing that was performed by ActMod.

3) Whether the choice of assumptions or combination of assumptions on which the rate increase is based is reasonable.

As noted throughout this Report, it is ActMod's opinion that Anthem's methodology and choice of Rate Filing assumptions are reasonable. ActMod notes that while "reasonable" is a subjective term, actuaries often apply "actuarial judgment" to develop opinions regarding the reasonableness of benefits in relation to premiums charged for rate filings. For the purpose of this Rate Filing, ActMod defines reasonable as having sufficient, credible, and relevant data such that an experienced actuary could review the available information and make an informed judgment by applying actuarial standards to determine the reasonableness of each relevant assumption used in the preparation of the Rate Filing. This definition is consistent with the review ActMod performed for this Rate Filing.

4) Whether the data, assumptions, rating factors, and methods used to determine the premium rates, or documentation provided to the Department in connection with the filed rate increase are incomplete, inadequate, fail to provide sufficient clarity and detail such that a qualified health actuary could not make an objective appraisal of the reasonableness of the rate, or which otherwise does not provide a basis upon which the reasonableness of the rate may be determined.

It is ActMod's opinion that the information that Anthem, in conjunction with this detailed Report, has provided the CDI for the Rate filing is adequate, complete, and a reasonable basis for the CDI's review of the Rate Filing. In addition to the rate tables Anthem filed with the CDI, Anthem prepared and provided both the CDI and ActMod the complete version of the Actuarial Memorandum shown as an excerpt in Attachment 8. This Actuarial Memorandum was prepared by the Reliance Actuary and provides further support for the Rate Filing.

Accordingly, it is ActMod's opinion that the data or documentation provided to the CDI in connection with the filed rate increases is sufficient and adequate for the CDI to determine the reasonableness of the requested rate changes.

5) Whether the filed rates result in premium differences between insureds within similar risk categories that:

a) Are otherwise not permissible under applicable California law; or

In ActMod's opinion, the Rate Filing has no rates or rating classifications between insureds that are not permissible under applicable California law.

b) Do not reasonably correspond to differences in expected costs.

For the various items discussed in this Report in conjunction with the identified reliances on the Reliance Actuary, it is ActMod's opinion that the premiums and rate changes in the Rate Filing do reasonably correspond to differences in expected costs.

6) Whether the specific, itemized changes that led to the requested rate increase are substantially justified by credible experience data for the prior three years, including comparisons of experience data to projections submitted as support for prior rate filings.

We reviewed the itemized changes (e.g. membership, benefit plan, premium, and claims information) in great detail and believe they are all justified by credible experience. As noted in the report, when credible experience data was not directly available (i.e. the experience data for the less than fully credible Products), we believe that Anthem used appropriate credible substitute data and made the appropriate adjustments to that data.

Therefore, it is ActMod's opinion that the requested rate changes are substantially justified by credible experience data.

7) The rate of return of the insurance company and the parent corporation/ultimate controlling party of that insurer, evaluated on a return-on-equity basis, for the prior three years, and anticipated rate of return for the following year, taking into account investment income.

Anthem provided ActMod what is included in this Report as Attachment 5 (for the insurer). Attachment 5 notwithstanding, the rate of return is not something that ActMod, nor do we believe other external actuarial consultants, would typically review in the context of a single Rate Filing, either at the insurer or parent company/ultimate controlling party level. Although information on the rate of return for the insurer is included, we do not believe it is relevant to the review and opinions expressed in this Report.

Accordingly, ActMod did not identify anything in the Rate Filing that would cause us to consider the Rate Filing to be unreasonable due to the company's rate of return.

8) The annual compensation of each of the 10 most highly paid officers, executives, and employees of both the insurer submitting the rate filing and the parent corporation/ultimate controlling party of that insurer.

Anthem provided ActMod what is included in this Report as Attachments 6(a) and 6(b). These Attachments consist of blank exhibits that show the compensation information included each year in Anthem's Statutory Statements annual filings. Of course, actual compensation information would accompany the Statutory Statement filings.

Other than noting that Anthem considers administrative expenses inclusive of employee and executive compensation expenses in the establishment of Target Loss Ratios, ActMod did not consider nor do we understand how an actuary would consider this type of information, whether at the insurer or parent corporation/ultimate controlling party level, in determining the reasonableness of a rate filing. Accordingly, ActMod did not identify anything in the Rate Filing that would cause us to consider the Rate Filing to be unreasonable due to employee and executive compensation.

9) The degree to which the increase exceeds the rate of medical cost inflation as reported by the U.S. Bureau of Labor Statistics Consumer Price Index for All Urban Consumers Medical Care Cost Inflation Index.

Anthem provided ActMod with the Table shown in Attachment 7. As previously noted the preparer of this Report, James P. Galasso, has over 30 years' experience involving health care pricing and related actuarial issues. During this time it has always been evident to Mr. Galasso and, we believe, the actuarial community in general that the Medical Care component of the Consumer Price Index materially understates Medical Trend in general and the medical cost drivers of health care premiums in particular.

Accordingly, ActMod added the "boxed" area to the right of the table in Attachment 7. The text in the boxed area is an excerpt from the Bureau of Labor Statistics website that explains some of the components of the Medical Care CPI. ActMod highlighted the last sentence that we believe is particularly relevant. Specifically, it notes that the Medical Care component of the CPI ". . . only includes consumers' out-of-pocket expenditures (and excludes employer provided health care). . ." The Medical Care component of the CPI also excludes government expenditures (e.g. Medicare and Medicaid payments) from the Medical Care component of the CPI.

With government alone accounting for approximately 50% of total health care spending in the United States and employers paying the preponderance of the remaining 50%, we seriously question the use of the Medical Care component of the CPI as an indicator against which rate increases for health insurance premiums should be compared.

We make this observation in support of our belief that the Medical Care component of the CPI is an arbitrary, artificial, and erroneous indicator with respect to the drivers of health insurance premiums. We also note that the rate changes for individually underwritten health insurance are subject to forces well in excess of what is captured by the Medical Care component of the CPI (e.g. Adverse Selection, Underwriting Wear-Off, and Medical Trend Leverage).

Accordingly, it is ActMod's opinion that the variance between the filed rate changes and the Medical Care component of the CPI should not be cause for the filed rates to be deemed "unreasonable".

10) Whether the cumulative impact of the filed rate, combined with the previous increases, would cause the rate to be unreasonable.

The cumulative average increase over the prior 12-month period for each Product impacted by the Rate Filing is shown in Step 26 of Attachment 14; as shown on Attachment 15, the increases range from a negative 25.4% to the Rate Capped amount of 29.9%. The negative 25.4% rate change for certain Subscribers is explainable and attributable to a combination of such items as changes in age factors and changes in geographic area factors. In ActMod's opinion, the non-negative rate changes are within a typical range for individually underwritten comprehensive health care policies.

Accordingly, it is ActMod's opinion that the cumulative impact of the filed rates should not be cause for such rates to be deemed "unreasonable".

11) The insurer's surplus condition and dividend history.

Consistent with ActMod's understanding of typical rate filing reviews by external actuaries, the scope of our engagement did not include a review of Anthem's surplus condition. This is not something that ActMod, nor do we believe other external actuarial consultants, would typically review in the context of a single rate filing.

Additionally, we do not consider it necessary or an integral part of the rate filing review process. In conclusion, while we have not reviewed the insurer's surplus condition and dividend history, we are of the opinion that such information does not have bearing on the development and ultimately, the "reasonableness" of the rates themselves.

12) Whether the rating factors applied and any change in rating factors are reasonable and result in a distribution of the proposed rate increase across risk categories that is reasonable and not overly burdensome on any particular individual or group, including consideration of the minimum and maximum rate increases a policyholder could receive, and how many policyholders will be subject to lower and higher than the average.

ActMod reviewed both the aggregate average rate change across Products and the distribution of the filed rate changes, including the minimum and maximum rate increases a policyholder could receive. The distribution by level of rate change is shown in Attachment 15.

The aggregate average rate change is 9.6% and the distribution of this average rate change across Products range from a minimum of a negative 25.4% to a maximum of 29.9%. The percentage of policyholders expected to receive these minimum and maximum rate changes are 2.4% and 0.1%, respectively.

As previously noted, the negative 25.4% rate change for 2.4% of Subscribers is explainable and attributable to a combination of such items as changes in age factors and changes in geographic area factors. In ActMod's opinion each of the above noted non-negative rate change parameters is consistent with the range of rate changes typical for individually underwritten health care policies and, accordingly, we believe the rate changes and their distribution are reasonable.

ActMod is not qualified to offer an opinion as to whether or not the rate increases in this Rate Filing may be "overly burdensome" either collectively or with respect to any particular individual or group.

13) The nature and amount of transactions between the filing insurer and any affiliates over the prior 3 years.

This is not something that ActMod, nor do we believe other external actuarial consultants, would typically review in the context of a rate filing. Additionally, we do not consider it necessary or an integral part of the rate filing review process. In conclusion, while we have not reviewed the transactions of the company or its affiliates, we are of the opinion that such information does not have bearing on the development and ultimately , the "reasonableness" of the rates themselves.

14) For individual policies, whether the proposed rates comply with California Code of Regulations Title 10, section 2222.12 (the "California Code"). ***ActMod note: The California Code defines and requires that the Lifetime Anticipated Loss Ratio (the "Lifetime MLR") and "the anticipated loss ratio over the future period for which the revised rates are computed to provide coverage" (the "Future MLR") must each be not less than 70.0%. The recent revision to the California Code also requires that proposed rates comply with ACA-defined minimum MLR requirements.***

As stated in Section V of this Report, it is ActMod's opinion that the Rate Filing complies with the 70% Lifetime minimum MLR requirements of the California Code.

As also discussed in the above Section A item (1) that addresses compliance with the SB 1163 Guidance, in ActMod's opinion the Rate Filing complies with the ACA-defined minimum MLR requirements.

Section C: Actuarial Certification

20) (A) The Actuarial Certification is considered:

In this Section 20) (A) and Section 20) (B) below, the pronouns "I", "me", and "my" refer to James P. Galasso; please also be advised that the use of the "I", "me", or "my" pronoun does not preclude the possibility of Mr. Galasso's use of support personnel in the preparation of this Report.

(1) A "Statement of Actuarial Opinion"

I understand that this Report is deemed to be a Statement of Actuarial Opinion and I have prepared the Report, to the best of my ability, to comply with my professional obligations in this regard.

(2) A "Health Filing", as defined in Actuarial Standard of Practice ("ASOP") No.8

I understand that the Rate Filing subject to review by this Report is considered a Health Filing and, as such, is subject to the actuarial standards described in ASOP No. 8.

(3) An "Actuarial Communication", as defined by ASOP No. 41

I understand that this Report is deemed to be an "Actuarial Communication" and I have prepared the Report, to the best of my ability, to comply with my professional obligations in this regard.

(B) The Actuarial Certification must include:

(1) A statement (i) describing the actuary's qualifications, (ii) that the actuary meets the Qualification Standards for *Actuaries Issuing Statements of Actuarial Opinion in the United States*, and (iii) that the actuary meets California's legal requirements for independence.

Section VI of this Report outlines my qualifications to issue this certification and notes that I meet the Qualification Standards for *Actuaries Issuing Statements of Actuarial Opinion in the United States* to issue the opinions contained herein. I also meet the independence requirements stated in the California Insurance Code section 10181.6 (b) (3).

(2) A statement of opinion that the proposed premium rates in the filing are actuarially sound in aggregate for the market segment (i.e. small group or individual). Premium rates are actuarially sound if, for business in California and for the period covered by the certification, the total of projected premium income, expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income is adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of required capital.

I affirmatively state that, in my opinion, the filed premium rates are actuarially sound for the business in California and for the period covered by the certification (i.e. the Rating Period). I reviewed the projected premium income, any expected reinsurance cash flows (there were none), and any governmental risk adjustment cash flows (there were none).

As noted in Section II, the projection period assumed the proposed rates would be effective July 1, 2012 and May 1, 2012 for the Closed NGF Benefit Plans and the Open NGF Benefit Plans, respectively. For actuarial soundness to be maintained, the rates need to be implemented in accordance with the time table assumed by the Rate Development process.

I did not review, however, investment income as regards the benefit plans impacted by the Rate Filing. In my opinion, investment income for short term medical care policies is typically not explicitly considered during the rate development process. The reason is that, unlike for longer term product offerings such as disability income policies or long term care insurance, investment income is generally not a significant part of the income stream for short term medical care policies.

With respect to expected costs, I reviewed the expected cost of health benefits (i.e. claims expenses), but I did not review underlying administrative expenses such as marketing and administrative expenses nor did I review the cost of required capital. The reason that I did not conduct such a detailed review is because Anthem prepared the Rate Filing and the Rate Development Process using what is typically known as the "Loss Ratio" approach.

The Loss Ratio approach merely requires the establishment of Target Medical Loss Ratios that are in compliance with all relevant laws and regulations and are deemed satisfactory to the company. In this case, Anthem has assured me that it is comfortable with the chosen Target Medical Loss Ratios and I verified, to the best of my ability, that the ultimate proposed Medical Loss Ratios complied with all appropriate laws and regulations.

For the "cost of required capital", in my opinion it is not typical for individual health care rate filings to explicitly include a factor for the "cost of required capital". Rather, it is far more common for a company to prepare a rate filing with an MLR it believes is acceptable and that provides for an implicit or explicit profit margin sufficient to cover the "cost of required capital" when considered in the context of an entire company's financial performance goals and objectives.

I verified, to the best of my ability, that the ultimate expected Medical Loss Ratios complied with all appropriate laws and regulations. I also reviewed the aggregate Medical Loss Ratio with respect to my understanding of industry norms for individual health care policies and, in my opinion, the aggregate Medical Loss Ratio in this Rate Filing is reasonable in the context of such industry norms.

With the above understanding, I affirmatively state that, in my opinion, the filed premium rates are actuarially sound for the business in California and for the period covered by the certification (i.e. the Rating Period).

(3) For each contract or insurance policy included in the filing, a complete description of the data, assumptions, rating factors, and methods used to determine the premium rates, with sufficient clarity and detail that another qualified health actuary can make an objective appraisal of the reasonableness of the data, assumptions, factors, and methods. The descriptions must include examples of rate calculations for each contract or policy form included in the filing.

In my opinion, I covered the Rate Development process and described the data, assumptions, factors, and methods in sufficient detail such that a qualified health actuary could make an objective appraisal of my opinions and the reasonableness of the premiums and rate changes proposed in the Rate Filing.

Given the acknowledged complexity of the Rate Filing preparation process, I am also agreeable to responding to any questions or concerns that may require clarification.

I trust that Attachments 14(a) through 14(d) (the Rate Development Process) and the corresponding detailed explanations in Section IV. H. satisfy the requirement that "descriptions must include examples of rate calculations for each contract or policy form included in the filing".

(4) A statement of opinion, with respect to each individual or small group rate increase included in the filing, whether the rate increase filed is reasonable or unreasonable and, if unreasonable, that the justification for the increase is based on accurate and sound actuarial assumptions and methodologies, including benefit relativities that reflect the expected variations in cost, taking into consideration historical experience and the credibility of the historical data. Statements of opinion regarding whether a rate increase is reasonable or unreasonable shall discuss the factors listed in Section A, "Unreasonable Rate Increases," of this Guidance. In addition, statements of opinion regarding individual health insurance shall discuss whether the benefits provided under the policy are reasonable in relation to the premium charged, as described in California Code of Regulations title 10, chapter 5, section 2222.10, et seq.

Based on the information discussed in Section A above, it is my opinion that each of the rate increases in the Rate Filing is reasonable.

(5) A description of the testing performed by the actuary to arrive at the statements of opinion in paragraphs (B)(2) and (B)(4) above, including any independent rating models and rating factors utilized.

My review consisted mostly of a thorough review of the detailed information and data files provided to me by Anthem. I did format and accumulate certain information included in the Attachments in an effort to present this information as clearly as possible. I also tested the following key rating assumptions:

(i) Testing of Seasonality Factors: I developed Seasonality Factors for a different period to test for sensitivity. The revised Seasonality Factors resulted in average rate increases approximately 1.5% greater than those presented in this Rate Filing. Assuming theoretical accuracy somewhere between the results produced by Anthem's seasonality factors and ActMod's test factors, we concluded that the filed results are within a reasonable range of what can be considered actuarial uncertainty.

(ii) Testing of Maternity Mandate Assumptions: I tested the reasonableness of the expected cost impact of the State-mandated maternity benefit assumed by Anthem by using ActMod's proprietary pricing tool. I compared Anthem's plus 2% (for Closed NGF Benefit Plans) and plus 5% (for Open NGF Benefit Plans) incremental cost assumption for benefit plans not currently covering maternity costs and Anthem's 2.5% credit for benefit plans that currently cover maternity costs against our pricing tool that showed total maternity costs generally comprise about 8% of total medical costs for a typical insured population not subject to Adverse Selection. I concluded that Anthem's assumptions were reasonable but at the lower end of what I anticipate will be the ultimate cost of complying with the maternity benefit mandate.

ActMod thanks Anthem for the opportunity to prepare this Report and would be pleased to respond to any questions or supplement the Report as may be deemed necessary.

Respectfully submitted,

James P. Galasso, FSA, MAAA, CERA
President & Consulting Actuary
Actuarial Modeling

Attachments

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Jim Galasso is a Fellow in the Society of Actuaries, a Member of the American Academy of Actuaries, and a Chartered Enterprise Risk Analyst. He has over 30 years' experience in health care, serving in the capacity of Chief Financial Officer, Chief Actuary, and as an Actuarial Consultant. Prior to incorporating and serving as the President & Actuarial Consultant for Actuarial Modeling, Mr. Galasso served as a Partner with Ernst & Young LLP, managing E&Y's southeast actuarial healthcare practice.

Mr. Galasso has performed various actuarial services for numerous Commercial Insurance Carriers, Blue Cross Blue Shield Plans, Health Maintenance Organizations, Governmental Entities, Health Care Providers, and Large Employers. Such services include but are not limited to:

(1) Actuarial & Financial Due Diligence
(2) Actuarial Reserve Reviews (including IBNR and Premium Deficiency Reserves)
(3) Actuarial Valuations
(4) Group Health Employee Benefit Programs
(5) Pricing Medical Care Benefit Plans
(6) Reviewing Prescription Drug Programs [including Pharmacy Benefit Managers (PBM)]
(7) Risk-Based Capital Reviews
(8) Health plan organization realignments
(9) Predictive Risk Modeling / Health Risk Adjusters
(10) Underwriting policy and procedure reviews
(11) Rate filing preparations and testimony
(12) Provider contracting and network management
(13) Risk assessments for Provider Sponsored Organizations
(14) Merger and Acquisition engagements
(15) Medicare Supplement Products
(16) Medicare and Medicaid managed care programs
(17) Blue Cross and Blue Shield audits and actuarial consulting
(18) HMO and PSO audits and actuarial consulting
(19) Behavioral health audits and actuarial consulting
(20) Expert Witness Testimony
(21) Serving on Arbitration Panels

Professional Experience

Mr. Galasso has developed a comprehensive package of actuarial and financial reporting tools consisting of, but not limited to, the following:

(1) An "Incurred But Not Reported" (IBNR) estimation software model
(2) A medical cost & premium development software model for healthcare companies
(3) An aggregate and specific stop loss rating software model
(4) A MediGap pricing software model that accommodates both 1990 and 2010 standard plans
(5) A large group underwriting software model
(6) A physician fee evaluation software model
(7) A hospital reimbursement evaluation software model
(8) A prescription drug evaluation software model
(9) A financial projection software model for healthcare companies
(10) A market segment reporting and trend monitoring software model
(11) A capital management and risk-based capital analysis software model
(12) A process for monitoring, pricing, and underwriting groups and group rating parameters

Qualifications

Mr. Galasso maintains his standing as a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and a Chartered Enterprise Risk Analyst by pursuing continuing education credits, frequently speaking at various actuarial conferences, publishing actuarial papers, and developing / presenting to actuaries various actuarial training courses for continuing education credit. Papers written by Mr. Galasso and offered to the actuarial community include:

(1) Financial Reporting for Health Care Companies
(2) Incurred But Not Paid ("Reported") Claim Liabilities ("IBNR") – The Basics
(3) Risk-Based Capital - the Basics
(4) Block Underwriting for Health Care Companies

Seminars and Training

Mr. Galasso attends and/or speaks at various seminars and conferences sponsored by the Society of Actuaries, the Southeastern Actuaries Conference, and other industry conferences.

Education

Mr. Galasso graduated with honors from the State University of New York at Stony Brook with majors in both Theoretical and Applied Mathematics. His post graduate activities included studying for and successfully completing the series of examinations offered by the Society of Actuaries, culminating in Mr. Galasso's obtaining his Fellowship in the Society of Actuaries.

Actuarial Reliance Certification

I, Fritz Busch, am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I meet the American Academy of Actuaries continuing education standards and am qualified to have prepared and/or reviewed the actuarial analysis and data that I provided to Mr. James P. Galasso for his review and certification of the Rate Filing entitled “Individual Rates effective May 1, 2012 / July 1, 2012”. This Rate Filing covered certain open and closed Non-Grandfathered Benefit Plans, was prepared by the Anthem Blue Cross Life and Health Insurance Company, and filed with the California Department of Insurance.

Fritz Busch, FSA, MAAA
Regional Vice President Individual
WellPoint Inc.

1. Adverse Selection - One of the most challenging issues that health insurance companies must contend with in a voluntary and competitive market is the ability of each prospective or current Member to forego health insurance or to select the benefit plan and insurance company that offers the most attractive alternative. While the common industry term for this phenomenon is "Adverse Selection", some, perhaps more appropriately, refer to the phenomenon as "Intelligent Individual Selection".

   In addition to Adverse Selection attributable to benefit plan differences (i.e. healthier Members are more likely to select lower cost plans with higher Cost Sharing provisions and the opposite is the case for less healthy Members), Adverse Selection is also impacted by provider network differences. Less healthy Members are more likely to prefer and pay additional premiums for access to a broad selection of health care providers while healthier Members are more likely to be satisfied with a narrower selection of health care providers in exchange for lower premiums.

   Historically, health insurance companies have protected themselves from Adverse Selection attributable to new sales and/or transferring coverage to a different benefit plan via the Medical Underwriting process (see Medical Underwriting).

2. Affordable Care Act ("ACA") – The two health care reform bills enacted into law on March 23, 2010 called the "Patient Protection and Affordable Care Act" and the "Health Care and Education Affordability Reconciliation Act of 2010" are collectively referred to as the "Affordable Care Act".

3. Allowed Claims (or, Allowed Charges) – Allowed Claims represent the amount a health care provider bills a managed care organization **after** the application of contractual discounts negotiated with the managed care organization and **after** benefit coverage provisions are considered but **before** member cost sharing provisions are considered.

4. Base Period (also referred to as Experience Period) – This is a term used by actuaries when they must project future medical costs and related data (e.g. members and premiums) for a defined purpose. The Base Period is derived from a recent subset of the Experience Data. The actuary often uses the Base Period to project future expected experience (e.g. for a defined Rating Period).

5. Base Rate (also referred to as Manual Rate) – The Base Rate for a defined population is determined by applying the demographic characteristics of the population to a company's Rate Tables. The actual morbidity of the population is not considered (see Experience Rate and Rate Basis).

6. Billed Claims (or, Billed Charges) – Billed Claims represent the amount a health care provider bills a managed care organization **before** the application of contractual discounts negotiated with the managed care organization and **before** member cost sharing and benefit coverage provisions are considered (see Covered Claims).

7. Closed Product Line - A Product Line that is no longer being marketed (i.e. the Product Line is no longer available to new Members).

8. Cost Sharing – Cost Sharing refers to the amount of Allowed Charges that a Member must pay for health care services over and above that paid by a health care plan. The most common cost sharing provisions consist of deductibles, copayments, and coinsurance amounts. Benefit limitations such as calendar year limits may also result in Cost Sharing.

9. Covered Claims – Covered Claims are the same as Billed Claims with the exception that claims not covered by a benefit plan are excluded.

10. Experience Data – This is a term used by actuaries to define the data (e.g. members, premium, and medical claims) that is often used for projection purposes. The data used for a defined Base Period is generally a subset of the Experience Data.

11. Experience Rate – This is the premium rate for a defined population that reflects the underlying morbidity characteristics of the population. This contrasts with the Base Rate for a population (see also Rate Basis).

12. Grandfathered Benefit Plans ("GF" Benefit Plans) – Policy Forms sold prior to March 23, 2010 do not have to conform with all of the ACA-mandated benefits as long as the benefits and cost sharing provisions are not materially changed. These Policy Forms are referred to as Grandfathered ("GF") Benefit Plans (see also Non-Grandfathered Benefit Plans).

13. Managed Care Organization ("MCO") – Third party health care payers that negotiate contracts with health care providers to provide services to its Members are often referred to as Managed Care Organizations.

14. Medical Costs – This is an industry term that is used to refer to medical claim payments plus other medical costs and/or credits (i.e. capitation payments to providers or provider organizations, provider risk sharing payments or receivables, Rx Rebates, medical management expenses properly classified as medical expenses, etc.).

15. Medical Loss Ratio ("MLR") – While the subject of multiple definitions, in its most basic form (and, unless otherwise stated, as used in this Report), an MLR is defined as Incurred Medical Costs divided by Earned Premiums for a defined period of time. The ACA-defined MLR differs and is defined by the following:

    (a) Numerator = Medical Costs (inclusive of medical management expenses that improve the quality of medical care) plus the impact of Policy Contract Reserves (also known as Active Life Reserves), if any.

    (b) Denominator = Earned Premium less State and Federal Taxes

16. Medical Loss Ratio Durational Factors – Health care companies generally review and consider an applicant's medical history prior to issuing an individually underwritten health care policy (see Underwriting Tier). Accordingly, the claims costs and/or MLR of policies during the initial years following issuance can be expected to be materially lower than the claims costs and/or MLR for longer duration policies. That is, the policies remaining in force several years after issue reflect several factors which cause their claims cost and/or MLR to be greater than that of more recently issued policies – even for policyholders of the same age and other demographic characteristics. The factors used to measure this phenomenon (i.e. the relationship of the MLR for a given duration to the MLR for a defined normative duration) are called MLR Durational Factors.

17. Medical Loss Ratio Durational Wear-Off Factor – The change in the MLR Durational Factors from one period to a subsequent period is generally referred to as the MLR Durational Wear-Off Factor (or, the Underwriting Wear-Off Factor).

18. Medical Trend (Claims Cost Trends, Claims Trend, or Claims Trend Factor) – The actual and/or expected change in claims cost (the claims costs are generally expressed on a Per Member Per Month, or "PMPM" basis) over a defined period of time (the change, or Medical Trend, is generally expressed as a percentage in annualized terms).

19. Medical Trend Leverage – The mathematical phenomenon that causes Medical Trends to be higher for benefit plans with fixed cost sharing provisions such as calendar year deductibles or fixed copays (e.g. all else being equal, a benefit plan will experience higher medical cost trends to the extent it has a fixed calendar year deductible that is higher than that of another similar benefit plan). This is due to the fixed cost sharing provisions offsetting a smaller proportion of a total benefit plan's claims cost as overall costs increase but the fixed cost sharing provisions remain fixed.

20. Medical Underwriting – The selection process that MCOs often use to review the medical history of an applicant for a health care plan to determine the health status of the applicant. After evaluating the applicant's health status, the MCO will generally assign the applicant (or, group of applicants for a group health care plan) to an Underwriting Tier.

21. Member – Member is the term most commonly used to describe any participant in a health care plan, whether that participant be a Subscriber or a dependent of a Subscriber.

22. Member Months – The average number of Members covered during a defined time period multiplied by the number of months in that time period. Member Months is also used to describe the average number of Members covered for each day within a given month.

23. Months of Movement (also called "Trend Months") – This is a term used to measure the average number of months from the Base Period to the Rating Period. Months of Movement equals the number of months between the midpoint of the Base Period and the midpoint of the Rating Period.

24. Non-Grandfathered Benefit Plans ("NGF" Benefit Plans) –Policy Forms sold after March 23, 2010 are required to comply with the ACA-mandated benefits by the later of (i) the policy effective date and (ii) the first renewal/rate change date after September 23, 2010. These Policy Forms are referred to as Non-Grandfathered ("NGF") Benefit Plans (see also Grandfathered Benefit Plans).

25. Open Product Line - A Product Line that is actively marketed (i.e. the Product Line is made available to new members).

26. Paid Claims - Unless otherwise stated this Report refers to Paid Claims as the amount a health care provider bills a managed care organization **after** the application of contractual discounts negotiated with the managed care organization, **after** benefit coverage provisions are considered, and **after** member cost sharing provisions are considered. Paid Claims must often be distinguished from Incurred Claims but unless otherwise stated, this Report will use the terms Paid Claims and Incurred Claims interchangeably to distinguish them from Allowed Claims (see Definition above). Paid Claims generally refers to claims actual paid by a managed care organization. Incurred Claims refers to claims paid plus claims incurred but not yet paid (i.e. Paid Claims plus a liability estimate for claims incurred but not yet paid).

27. Per Member Per Month ("PMPM") – Dollar values in the managed care industry are often expressed on a Per Member Per Month ("PMPM") basis. For example, the average premium and Medical Costs for Members for one month or for a series of months (such as the Experience Period or the Rating Period) are often expressed as PMPMs, which is calculated by dividing the total dollars for the period in the form of Medical Costs or premiums paid by the total number of Member Months that generated those dollars.

28. Policy Duration – The length of time (usually in years) since the issue date of a health care policy.

29. Policy Form (or, "Plan Family", or "Product Line") – The terms Policy Form, Plan Family, or Product Line are often used to define a group of benefit plans that may have similar but not identical cost sharing provisions. Sometimes Product Line is used to describe a subset of a Policy Form (i.e. Product Line may include benefit plans with cost sharing provisions at a more granular level than the Policy Form or Plan Family).

30. Provider Network – The medical care providers (e.g. Hospitals, Physicians, other health care professionals) and service organizations (e.g. pharmacy benefit managers, laboratories, radiology centers) that have contracted with a MCO to provide medical services to the MCO's Members.

31. Rate Basis – Actuaries must often compare the morbidity of a population to a company's standard Base Rates. This is often accomplished by comparing the Experience Rate for a defined population to the Base Rate for the same population.

32. Rate Tables – These are the Rate Tables that an MCO often uses as the basis for developing a Subscriber-specific rate (e.g. a rate that reflects the Subscriber's benefit plan, family tier, geographic area, and other Rating Characteristics that may impact a Subscriber's rate).

33. Rating Characteristics – This term refers to the various rating categories that may impact the particular rate of a Subscriber. Permissible Rating Characteristics often include: Age, Gender, Health Status (i.e. Underwriting Tier), Benefit Plan, Geographic Area, and Family Tier.

34. Rating Period – This is a term used by actuaries to define the time period for which future medical costs are to be projected for premium rating purposes.

35. Retention – Retention is an industry term that is used to describe the portion of the premium dollar estimated to provide for all items other than Medical Costs. Examples of Retention items include: Administrative Expenses, Selling Expenses, Premium Taxes, and Profits. Retention is generally expressed as either a percentage of premiums or a fixed dollar amount PMPM. When expressed as percentages of premiums, the total of all Retention items is equal to the complement of the basic MLR (i.e. 100% minus the MLR = Retention).

36. Risk Adjusting – This is an actuarial term used to describe a system that is designed to neutralize within or across companies the financial impact of servicing a more or less favorable population with respect to the population's health status. The companies or entities involved might include, for example, MCOs, providers, or classes of employees of a large employer.

37. Seasonality – This is the term used to describe the phenomenon that medical claims costs often vary by calendar month. This is especially true for benefit plans with high calendar year deductibles since claim payments for these plans are generally lower in the early months of a calendar year and increase in the latter months of a calendar year. That is, in the early months of a calendar year, a greater portion of claims are subject to the benefit plan deductibles that are the responsibility of the Member.

38. Subscriber – This is a term that is often used to describe the purchaser of a health care policy. The health care policy itself may cover only the Subscriber (i.e. a "Single" policy) or the Subscriber and his or her dependents (i.e. a "Family" policy).

39. Underwriting Tier (or, Risk Tier) – This term refers to the classification of Members into defined categories determined by the Health Status of the Member.

40. Underwriting Wear-Off – (See "Medical Loss Ratio Durational Wear-Off Factor")

STATE OF CALIFORNIA
Dave Jones, *Insurance Commissioner*

DEPARTMENT OF INSURANCE
Legal Division
45 Fremont Street, 24th Floor
San Francisco CA 94105

Guidance 1163: 2

Draft release date: February 3, 2011
Final release date: April 5, 2011

Pursuant to Senate Bill 1163 (Chapter 661, Statutes 2010), the California Department of Insurance issues the following guidance regarding compliance. [1] Further guidance may be forthcoming in the future.

Section A: Unreasonable Rate Increases

For all health insurance filings, for the purpose of the actuarial certification required under Insurance Code section 10181.6(b)(2) and review under Insurance Code section 10181.11, the factors the Department will consider in determining whether a rate increase is "unreasonable" include, but are not limited to, the following:

1) The relationship of the projected aggregate medical loss ratio to the federal medical loss ratio standard in the market segment to which the rate applies, after accounting for any adjustments allowable under federal law. See interim final rule entitled "Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act," (45 C.F.R. sections 158.101- 158.232, 75 Fed. Reg. 74921-74928, (December 1, 2010)), incorporated herein by reference.

2) Whether the assumptions on which the rate increase is based are supported by substantial evidence.

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[1] Senate Bill 1163 provides, at Insurance Code section 10181.2, that Article 4.5 (Insurance Code section 10181 *et seq.*) does not

> apply to a specialized health insurance policy; a Medicare supplement policy subject to Article 6 (commencing with Section 10192.05); a health insurance policy offered in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code); a health insurance policy offered in the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5)); a health insurance conversion policy offered pursuant to Section 12682.1; or a health insurance policy offered to a federally eligible defined individual under Chapter 9.5 (commencing with Section 10900).

Accordingly, the above guidance does not apply to the types of insurance listed in Insurance Code section 10181.2.

3) Whether the choice of assumptions or combination of assumptions on which the rate increase is based is reasonable.

4) Whether the data, assumptions, rating factors, and methods used to determine the premium rates, or documentation provided to the Department in connection with the filed rate increase are incomplete, inadequate, fail to provide sufficient clarity and detail such that a qualified health actuary could not make an objective appraisal of the reasonableness of the rate, or which otherwise does not provide a basis upon which the reasonableness of the rate may be determined.

5) Whether the filed rates result in premium differences between insureds within similar risk categories that:

(A) Are otherwise not permissible under applicable California law; or
(B) Do not reasonably correspond to differences in expected costs.

6) Whether the specific, itemized changes that led to the requested rate increase are substantially justified by credible experience data for the prior three years, including comparisons of experience data to projections submitted as support for prior rate filings."

7) The rate of return of the insurance company and the parent corporation/ultimate controlling party of that insurer, evaluated on a return-on-equity basis, for the prior three years, and anticipated rate of return for the following year, taking into account investment income.

8) The annual compensation of each of the 10 most highly paid officers, executives, and employees of both the insurer submitting the rate filing and the parent corporation/ultimate controlling party of that insurer.

9) The degree to which the increase exceeds the rate of medical cost inflation as reported by the U.S. Bureau of Labor Statistics Consumer Price Index for All Urban Consumers Medical Care Cost Inflation Index.

10) Whether the cumulative impact of the filed rate, combined with the previous increases, would cause the rate to be unreasonable.

11) The insurer's surplus condition and dividend history.

12) Whether the rating factors applied and any change in rating factors are reasonable and result in a distribution of the proposed rate increase across risk categories that is reasonable and not overly burdensome on any particular individual or group, including consideration of the minimum and maximum rate increases a policyholder could receive, and how many policyholders will be subject to increases lower and higher than the average.

13) The nature and amount of transactions between the filing insurer and any affiliates over the prior 3 years.

14) For individual policies, whether the proposed rates comply with California Code of Regulations Title 10, section 2222.12.

15) To the extent not otherwise covered by the factors listed above, additional factors the Department will consider in determining whether a rate increase is "unreasonable" include, but are not limited to, the factors set forth in the most current version of 45 Code of Federal Regulations section 154.301.

Section B: Filing and Notice

16) For individual and small group health insurance policies, rate submissions for new products and rate increases for existing products must be filed at least 60 days prior to implementation. (Insurance Code section 10181.3(a), (b)(14).)

17) The filing requirements of Senate Bill 1163 (Insurance Code sections 10181.3, 10181.4, 10181.6, 10181.7) apply to new product rates and rate increases implemented on or after January 1, 2011. With respect to rate filings submitted to the department prior to January 1, 2011 that include rate changes which will be implemented as to any insureds after January 1, 2011, the insurer must provide the 60-day notice described in Insurance Code section 10113.9 or 10199.1 for those changes.

18) The consumer notice required by Insurance Code section 10113.9 or 10199.1 must be delivered concurrently with the submission of the rate filing to the department. The notice required by section 10113.9 must include the date on which the proposed rate increase will be applied to the individual(s) to whom the notice is addressed. If a rate filing is revised after its initial submission so as to change the rates, an additional 30-day notice meeting the requirements of Insurance Code sections10113.9 or 10199.1 must be provided reflecting the revised rate.

19) To demonstrate compliance with the notice requirements of Insurance Code sections 10113.9 and 10199.1, insurers shall file the following information for each policy form for which a filing has been submitted pursuant to Insurance Code section 10181.3 for rates effective on or after January 1, 2011:

a) The date the required information was filed with the Department, and
b) The date(s) that notice was provided as required by Insurance Code section 10113.9 or 10119.1, and
c) The date that the rate reflected in the filing was first implemented as to an insured.

This report should be filed through SERFF within 10 days after the date the rate was first implemented, with the notation "Rate Notice Compliance Report" in the "Filing Description" field under the "General Information" tab.

Section C: Actuarial Certification

20) (A) The certification required under Insurance Code section 10181.6 (b)(2) is a "Statement of Actuarial Opinion," as defined in the *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*, promulgated by the American Academy of Actuaries. Such a certification is also a "Health Filing," as defined in Actuarial Standard of Practice No. 8 promulgated by the Actuarial Standards Board, and it is also an "Actuarial Communication," as defined in Actuarial Standard of Practice No. 41 promulgated by the Actuarial Standards Board.

(B) The certification required under Insurance Code section 10181.6 (b)(2) must include the following information:

(1) A statement of the qualifications of the actuary issuing the certification. The actuary's qualifications must meet the standards stated in *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*. The statement of qualifications must include a statement that the actuary meets the independence requirements stated in Insurance Code section 10181.6 (b)(3).

(2) A statement of opinion that the proposed premium rates in the filing are actuarially sound in aggregate for the market segment (i.e., small group or individual). Premium rates are actuarially sound if, for business in California and for the period covered by the certification, the total of projected premium income, expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income is adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital.

(3) For each contract or insurance policy included in the filing, a complete description of the data, assumptions, rating factors, and methods used to determine the premium rates, with sufficient clarity and detail that another qualified health actuary can make an objective appraisal of the reasonableness of the data, assumptions, factors, and methods. The descriptions must include examples of rate calculations for each contract or policy form included in the filing.

(4) A statement of opinion, with respect to each individual or small group rate increase included in the filing, whether the rate increase filed is reasonable or unreasonable and, if unreasonable, that the justification for the increase is based on accurate and sound actuarial assumptions and methodologies, including benefit relativities that reflect the expected variations in cost, taking into consideration historical experience and the credibility of the historical data. Statements of opinion regarding whether a rate increase is reasonable or unreasonable shall address the factors listed in Section A, "Unreasonable Rate Increases," of this Guidance. In addition, statements of opinion regarding individual health insurance shall address whether the benefits provided under the policy are reasonable in relation to the premium charged, as described in California Code of Regulations title 10, chapter 5, section 2222.10, *et seq*.

(5) A description of the testing performed by the actuary to arrive at the statements of opinion in paragraphs (B)(2) and (B)(4) above, including any independent rating models and rating factors utilized.

(C) All of the information required in (B), above, must be contained within the actuarial certification.

Section D: Filing Requirements

21) Individual and small group health insurance rate filings for existing products must be accompanied by a "California Rate Filing Form" that discloses the information required by Insurance Code section 10181.3(b), submitted as a PDF document under the "Supporting Documentation" tab in SERFF, and accompanied by a completed "California Rate Filing Spreadsheet," as well as a separate spreadsheet containing rate information in response to question 10 of the Rate Filing Form. The "California Rate Filing Form" and the "California Rate Filing Spreadsheet," are on the Department's website; please see the "California Rate Filing Form" on the Department's website (http://www.insurance.ca.gov/0250-insurers/0500-legal-info/0200-regulations/HealthGuidance/index.cfm) for definitions of certain of the items required.

22) All health insurance rate filings for existing products must be accompanied by the "California Plain-Language Rate Filing Description", submitted as a PDF document under the "Supporting Documentation" tab in SERFF, and accompanied by a completed "California Plain Language Spreadsheet" (Insurance Code section 10181.7(d)). The form and the spreadsheet are on the Department's website; please see "California Plain-Language Rate Filing Description" on the Department's website (http://www.insurance.ca.gov/0250-insurers/0500-legal-info/0200-regulations/HealthGuidance/index.cfm) for the form and format of the items required.

23) Initial rate filings for new products for individual and small group health insurance must be accompanied by the "California New Product Rate Filing Form" that discloses the information required by Insurance Code section 10181.3(b), submitted as a PDF document under the "Supporting Documentation" tab in SERFF, accompanied by a spreadsheet containing the information described in the form. See "California New Product Rate Filing Form" on the Department's website (http://www.insurance.ca.gov/0250-insurers/0500-legal-info/0200-regulations/HealthGuidance/index.cfm) for definitions of certain of the items required.

24) The aggregate rate filing data report required by Insurance Code section 10181.3(c) need not be submitted with each separate rate filing but must be filed with the Department at least quarterly (no later than 5 calendar days after the end of the calendar quarter). Each such report must summarize the required data for the calendar quarter, as well as for the calendar year to date. The report should be identified in SERFF by placing "Aggregate Rate Filing Date Report" in the "Filing Description" field under the "General Information" tab. A form for this report will be provided in subsequent guidance. The

terms “Segment Type”, “Product Type”, and “average rate increase” will be defined as they are in the attached “California Rate Filing Form” for items 5, 4, and 13 respectively.

For questions, please contact Bruce Hinze at bruce.hinze@insurance.ca.gov.

#663184v2

Anthem Blue Cross Life & Health Insurance Company

Individual Business Return on Equity

($ in millions)

	AS Ref	2008 Actual	2009 Actual	2010 Actual	2011 Forecast
Total Company					
Statutory Net Income	IS L32	194.5	170.5	205.9	183.5
Statutory Capital & Surplus	BS L31	760.1	813.8	973.8	1,082.9
		25.6%	21.0%	21.1%	16.9%

Notes

1) 2008 - 2010 Statutory amounts from indicated exhibit/schedule in Statutory annual statement.

2) 2011 total company statutory amounts from projections provided to CA CDI on October 20, 2010

ANNUAL STATEMENT FOR THE YEAR 2010 OF THE Anthem Blue Cross Life and Health Insurance Company

SUPPLEMENTAL COMPENSATION EXHIBIT

For the Year Ended December 31, 2010
(To be filed by March 1)

PART 1 - INTERROGATORIES

1. The reporting insurer is a member of a group of insurers or other holding company system: Yes [X] No [ ] If yes, do the amounts below represent 1) total gross compensation paid to each individual by or on behalf of all companies which are part of the group: Yes [X]; or 2) allocation to each insurer: Yes [ ]
2. Did any person while an officer, director, or trustee of the reporting entity receive directly or indirectly, during the period covered by this statement any commission on the business transactions of the reporting entitiy? Yes [ ] No [X]
3. Except for retirement plans generally applicable to its staff employees, has the reporting entity any agreement with any person, other than contracts with its agents for the payment of commissions whereby it agrees that for any service rendered or to be rendered, that he/she shall receive directly or indirectly, any salary, compensation or emolument that will extend beyond the period of 12 months from the date of the agreement? Yes [ ] No [X]

PART 2 - OFFICERS AND EMPLOYEES COMPENSATION

1	2	Annual Compensation			
		3	4	5	6
Name and Principal Position	Year	Salary	Bonus	All Other Compensation	Totals
Pamela D. Kehaly (1) (2)	2010				
Chief Executive Officer	2009				
	2008				
1. R. David Kretschmer	2010				
Treasurer	2009				
	2008				
2. Nicholas L. Brecker, III	2010				
President	2009				
	2008				
3. Kathleen S. Kiefer	2010				
Secretary	2009				
	2008				
4. G. Lewis Chartrand	2010				
Assistant Secretary	2009				
	2008				
5. Cassie S. Kam (3)	2010				
Chief Financial Officer	2009				
	2008				
6. (4)	2010				0
	2009				0
	2008				0
7.	2010				0
	2009				0
	2008				0
8.	2010				0
	2009				0
	2008				0
9.	2010				0
	2009				0
	2008				0

PART 3 - DIRECTOR COMPENSATION

1	2	3	4
Name and Principal Position or Occupation	Compensation Paid or Deferred for Services as Director	All Other Compensation Paid or Deferred	Totals
(5)			0

The reporting insurer is a member of a group of insurers or other holding company system. The above amounts represent compensation paid to each individual by or on behalf of all companies which are part of the group. The total compensation (column 6) is the amount reported in the year-end W2 gross taxable wages.

1 Amounts earned in All Other Compensation (column 5) may include payouts earned under multi-year long term incentive plans, sales incentives, and the exercise of stock options granted in prior years.

2 Pamela D. Kehaly was hired and became Chief Executive Officer on August 30, 2010.

3 Cassie S. Kam became Chief Financial Officer on October, 25, 2010

4 There are no employees dedicated to Anthem Blue Cross Life and Health Insurance Company. Data has been reported for officers only.

5 Inside (i.e., employee) directors are not compensated for serving on the Board of Directors.

Unadjusted Medical Care CPI for All Urban Consumers

Source: Bureau of Labor Statistics; http://www.bls.gov/cpi/#tables
Rolling 12-mth Trends at End of Year

End of Year	Rolling 12-month CPI Trend
1981	10.8%
1982	11.6%
1983	8.7%
1984	6.2%
1985	6.2%
1986	7.5%
1987	6.6%
1988	6.5%
1989	7.7%
1990	9.1%
1991	8.7%
1992	7.4%
1993	6.0%
1994	4.8%
1995	4.5%
1996	3.5%
1997	2.8%
1998	3.2%
1999	3.5%
2000	4.1%
2001	4.6%
2002	4.7%
2003	4.0%
2004	4.4%
2005	4.2%
2006	4.0%
2007	4.4%
2008	3.7%
2009	3.2%
2010	3.4%

From: Bureau of Labor Statistics Website:
http://www.bls.gov/cpi/cpifact4.htm
For the medical care categories the CE collects information on household out-of-pocket expenses. These may include data such as healthcare services received, who received it, the amount of payment made, and insurance reimbursements received. Medical care expenditures eligible for the CPI include out-of-pocket expenses paid by the consumer. These include fees (not recouped through health insurance) that consumers paid directly to retail outlets for medical goods and to doctors and other medical providers for medical services, as well as health insurance premiums that consumers paid (including Medicare Part B). To arrive at the consumer out-of-pocket medical expense, the CE nets out direct insurance reimbursements to the consumer from the total amounts paid by the consumer.

Since medical care only includes consumers' out-of-pocket expenditures (and excludes employer provided health care), its share in the CPI is smaller than its share of gross domestic product (GDP) and other national accounts measures.

Note: CE = Consumer Expenditure Survey

Anthem Blue Cross Life and Health Insurance Company
Actuarial Memorandum
Individual Rates effective May 1, 2012 / July 1, 2012

The purpose of this filing is to establish rates for the forms below and certify that these rates are in compliance with the minimum lifetime loss ratio standard and federal loss ratio standard set in Title 10, California Code of Regulations, Section 2222.12.

The forms affected by this filing are Non-Grandfathered. The Non-grandfathered plans are comprised of two separate blocks – one open block and one closed block. The Closed policy forms were no longer available for sale as of September 23, 2010.

The filed average premium rate increase for policy forms included in this filing is 9.6%. The rates will be effective May 1, 2012 for the Non-Grandfathered Open plans, and July 1, 2012 for the Non-Grandfathered Closed plans.

This filing is not intended to establish target lifetime loss ratios and should not be interpreted as such. The lifetime loss ratio study described in the body of the memorandum is a test under a reasonable set of assumptions that the lifetime loss ratio and future lifetime loss ratios are above 70%.

1. Policy Form Numbers and Names

   A. Closed Forms – July 1, 2012 effective date:

Form R420 Individual PPO Plan
Form T160 Individual PPO HSA Compatible Plan
Form 1518 Basic PPO 1000
Form 7900 Basic PPO 1000
Form PE25 Basic PPO 1000 CLONE
Form PE26 Basic PPO 1000 CLONE
Form R418 Basic PPO 2500
Form R419 Basic PPO 2500 CLONE
Form DL96 CORE 5000
[IND CDHP HSA], Lumenos HSA
[IND CDHP HIA], Lumenos HIA
[IND CDHP HIA Plus], Lumenos HIA Plus
Form NM31 PPO Saver Plan
Form PE27 PPO Saver Plan CLONE
Form H062 PPO Share
[PPO Share 5000-R], PPO Share
Form 1929 PPO Share
Form 1930 PPO Share
Form P958 RightPlan PPO (No Rx Coverage option)
Form PE48 RightPlan PPO (Generic Rx Coverage option)
Form PE49 RightPlan PPO (Full Rx Coverage option)
[RightPlan 500], RightPlan
[INDSS] SmartSense
Form T773 Tonik ($1,500 Deductible option) (DN13)
Form T774 Tonik ($3,000 Deductible option) (DN14)
Form T775 Tonik ($5,000 Deductible option) (DN15)
[2010 Basic], ClearProtection
[INDCoreGuard], CoreGuard
[Premier], Premier

B. Open Forms – May 1, 2012 effective date:

HCR Premier 9.23.10, Premier Plus
Lumenos HSA Plus: HCR New HSA 9.23.10
Lumenos HSA 1500 Plus: HCR HSA 1500 9.23.10
Lumenos HSA 5000 Plus: HCR HSA 5000 9.23.10
New PPO Share: HCR Share 9.23.10
SmartSense Plus: HCR SS 9.23.10
New Tonik 5000: HCR Tonik 5000 9.23.10
ClearProtection Plus: HCR CP 9.23.10
CoreGuard Plus: HCR CG 9.23.10

2. Description of Benefits Provided
See Appendix for description of the benefits currently provided.

3. Filed Rate Changes
The rate changes effective May 1, 2012 (Open plans) and July 1, 2012 (Closed plans) will be an average rate increase of 9.6% from the previously filed rates.

The average rate increases are as follows:

A. All Non-Grandfathered Closed plans:
- August 2011 Members: 80,032
- Average Rate Change from Previously Filed Rate Eff 7/1/2012: 9.2%

B. All Non-Grandfathered Open plans:
- August 2011 Members: 126,201
- Average Rate Change from Previously Filed Rate Eff 5/1/2012: 9.7%

Our strategy is to soften the impact of rate changes including increases in a member's attained age (aging) on our members by applying subscriber adjustment factors, also known as "rate caps". Please note that due to the use of subscriber adjustment factors, the premium rate charged to an existing subscriber may be lower than the table rate.

This filing contains adjustments to rates that are driven solely by recent legislation. One of those changes is the age rating slope for Open forms. The Affordable Care Act ("ACA") requires carriers to adjust rates by age to be within a range of 3:1 for adults by 2014. In order to reduce the rate shock this will entail, we are beginning that process with this rate filing and transition the change over time through 2013 rather than waiting to make the adjustment in its entirety in 2014.

Area Factors used in the rating of these forms and the definitions of rating areas are being modified. There is no impact on the overall rate increase as the area factors have been normalized to be revenue neutral.

Region	Old Area Factors	New Area Factors	Current Area Factors		Revised Area Factors	
			Member %	Premium PMPM	Member %	Premium PMPM
1	**1.2690**	**1.3083**	4.1%	$ 209.17	6.4%	$ 215.16
2	**1.1700**	**1.1826**	7.8%	$ 189.52	11.8%	$ 187.86
3	**1.1200**	**1.1552**	8.6%	$ 175.04	8.1%	$ 181.63
4	**1.0710**	**1.0720**	17.7%	$ 176.35	22.3%	$ 174.09
5	**0.9720**	**0.9188**	26.4%	$ 154.47	15.9%	$ 147.71
6	**0.9060**	**0.8564**	24.8%	$ 144.15	24.8%	$ 136.27
7	**0.7830**	**0.7402**	10.6%	$ 130.10	10.6%	$ 122.99
All Regions			**100.0%**	**$ 159.96**	**100.0%**	**$ 159.96**

4. Premium Rate Structure

- Member level rated plans (SmartSense, Lumenos, Individual PPO Plans, PPO Saver, RightPlan PPO, ClearProtection, CoreGuard, Premier, SmartSense Plus, Lumenos Plus, ClearProtection Plus, CoreGuard Plus, Premier Plus):
  Premium rates vary by the attained age of each member. Premium rates also vary according to contract type, single or family, and by underwriting tier and region. The rate for a family contract is equal to the sum of all family members' rates. Only the three youngest dependent children are charged. The fourth dependent child and above are not charged.

- Single-only plans (Tonik & New Tonik 5000):
  Premium rates vary by the attained age of each member, and by underwriting tier and region.

- Contract level rated plans (PPO Share and New PPO Share, Basic Hospital):
  Premium rates vary by attained age of the subscriber, underwriting tier, region and by contract type. The contract types are Single, Subscriber and Spouse, Subscriber and Child, Subscriber and Children and Family. For Subscriber & Spouse or Family contracts, the rates are based on the age of the younger spouse.

Note that Closed forms have been closed to new sales since September 23, 2010.

For this rate increase to Closed forms, we are assuming that members' renewal dates will be adjusted to the latest of 1) July 2012 2) end of initial rate guarantee period and 3) six months after their previous renewal date. For Open forms, we are assuming that members' renewal dates will be adjusted to the latest of 1) May 2012 and 2) end of initial rate guarantee period. We are assuming that this is a one-time adjustment to the renewal dates and members will remain on the adjusted renewal month for the remaining projected years.

Pursuant to AB 2244 (2010), for the 12-month period following the effective date of coverage for a child who is not a late enrollee and who did not maintain coverage with a health care service plan or insurer for the 90-day period prior to application, a 20% surcharge above the highest allowable rate may be applied.

5. Expected Lifetime Loss Ratios

The Regulatory requirements set forth in Title 10, California Code of Regulations, Section 2222.12 require each policy delivered on or after 7/1/2007 and also each policy that receives a rate revision on or after 7/1/2007, benefits shall be deemed reasonable in relation to premiums if: 1) the anticipated lifetime loss ratio is not less than 70 percent, and 2) the anticipated future-only lifetime loss ratio is also not less than 70 percent. All of Anthem's policy forms set forth in this memorandum are subject to the 70 percent standard.

We have conducted a study of the anticipated lifetime loss ratio of the policy forms included in this filing, where the anticipated lifetime loss ratio is defined to be the ratio of (i) divided by (ii), where (i) is the sum of the accumulated value of past incurred claims and the present value of future anticipated claims, and (ii) is the sum of the accumulated value of past earned premiums and the present value of future anticipated premium earnings. For this study, the future anticipated claims and premium were projected out to 2025.

Note that the lifetime loss ratio calculation is a test for regulatory compliance and is neither a target nor the basis for the filed rate increase. The results of Anthem's updated anticipated lifetime loss ratio calculations are summarized in the following table:

Form Grouping	Aug-2011 Members	Lifetime Loss Ratio	Future Lifetime Loss Ratio
Non-Grandfathered Closed	80,032	88.4%	91.9%
Non-Grandfathered Open	126,201	86.2%	86.6%
Total	206,233	86.4%	86.9%

The projected 86.4% lifetime loss ratio does not imply we are targeting 13.6% for expenses and margins. The projected lifetime loss ratio could increase or decrease depending on internal or external factors, but will be targeted to always satisfy regulatory minimum requirements.

Assumptions

A. Non-Grandfathered Closed Forms

1. The assumed leveraged underlying claims trends, excluding the effects of duration and aging:

   13.6% for 2011 – 2025

   The underlying claims trend assumption is based on recent historical claims trends and anticipated future trends. Trend and leveraging methodology has remained largely unchanged since previous filings.

The trend assumptions above vary according to the anticipated leveraging impact of deductibles and fixed copays.

2. The interest rate used to accumulate past values and discount future values is 3.57%.

3. The filed premium increase is 9.2% effective 7/1/ 2012. Rate increases are capped at 14.9% after the effects of aging and subscriber adjustment factors.

4. The assumed premium increases from 2013 and going forward are 13.6%. The assumed premium increases in the projection period 2013-2025 are assumed to be equal to the claims trend for the purposes of the lifetime loss ratio calculation.

5. The assumed claims durational curve based on Anthem's historical data is:

Length of Time in Plan	Claims Durational Factors
quarter 1	0.683
quarter 2	0.832
quarter 3	0.916
quarter 4	0.965
year 2 *	1.000
year 3	1.039
year 4	1.095
year 5	1.166
year 6	1.268
year 7	1.397
year 8	1.547
year 9	1.703
year 10	1.849
year 11+	1.929

*note: year 2 is set by convention to be one.

6. The assumed premium durational curve based on Anthem's historical data is:

Length of Time in Plan	Premium Durational Factors
quarter 1	0.934
quarter 2	0.954
quarter 3	0.968
quarter 4	0.982
year 2 *	1.000
year 3	1.025
year 4	1.061
year 5	1.107
year 6	1.164
year 7	1.229
year 8	1.301
year 9	1.376
year 10	1.447
year 11+	1.510

*note: year 2 is set by convention to be one.

7. Subscribers will experience the rate increase on their assigned renewal month. The assumed distribution of renewal months is:

Month	% Renewing
May-12	0.0%
Jun-12	0.0%
Jul-12	94.0%
Aug-12	0.0%
Sep-12	0.5%
Oct-12	5.5%
Nov-12	0.0%
Dec-12	0.0%
Jan-13	0.0%
Feb-13	0.0%
Mar-13	0.0%
Apr-13	0.0%
May-13	0.0%
Jun-13	0.0%

For Closed forms, we are assuming that members' renewal dates will be adjusted to the latest of 1) July 2012 2) end of initial rate guarantee period and 3) six months after their previous renewal date.

8. Other Claims Impacts
The following claims impacts are assumed in the lifetime loss ratio calculation:

- Benefit Reductions effective on January 1, 2012:
Benefit changes and impacts were described in previous 2011 filing #PF-2011-00002. We are making no additional decreases to benefits, and are no longer changing the drug formulary as was listed in filing #PF-2011-00002.

- Additional Autism Benefits effective on July 1, 2012:
In accordance with Senate Bill 946, chaptered 10/09/2011, we will be providing coverage for behavioral health treatment for pervasive developmental disorder or autism. We will add these benefits for all forms in this filing on July 1, 2012 as required.

- Maternity Benefits effective on July 1, 2012:
In accordance with Senate Bill 222, chaptered 10/06/2011, all forms will provide coverage for maternity services. We will add these benefits for all forms in this filing on July 1, 2012 as required.

Benefit Change	Impact to Claims PMPM
Benefit Reductions	-3.7%
Autism Benefits	0.6%
Maternity Benefits	1.3%

Methodology

Lifetime Loss Ratio = C / P

Let i = the month of past (historical) or projected PMPM experience.

$$C = \sum_{i=1}^{\infty} \text{FV}(\text{Past Claims PMPM}_i \times \text{Membership}_i) + \sum_{i=1}^{\infty} \text{PV}(\text{Projected Claims PMPM}_i \times \text{Membership}_i)$$

$$P = \sum_{i=1}^{\infty} \text{FV}(\text{Past Premium PMPM}_i \times \text{Membership}_i) + \sum_{i=1}^{\infty} \text{PV}(\text{Projected Premium PMPM}_i \times \text{Membership}_i)$$

Where FV means the accumulated value and PV means the present values.

Future Lifetime Loss Ratio = FC / FP

Let i = the month of past (historical) or projected PMPM experience.

$$FC = \sum_{i=1}^{\infty} \text{PV}(\text{Projected Claims PMPM}_i \times \text{Membership}_i)$$

$$FP = \sum_{i=1}^{\infty} \text{PV}(\text{Projected Premium PMPM}_i \times \text{Membership}_i)$$

Where PV means the present values.

Policies sold on or after 7/1/2007 or policies that experience a rate revision on or after 7/1/2007 are subject to the 70% lifetime loss ratio standard.

For the purposes of calculating the values over the lifetime of the policy, future values are discounted to July 1, 2012 for Non-Grandfathered Closed. Past values are accumulated to July 1, 2012 for Non-Grandfathered Closed. Note that the calculation ends with projected claims data through 12/31/2025.

B. Non-Grandfathered Open Forms

1. The assumed leveraged underlying claims trends, excluding the effects of duration and aging:

   13.9% for 2011 – 2025

   The underlying claims trend assumption is based on recent historical claims trends and anticipated future trends. Trend and leveraging methodology has remained largely unchanged since previous filings.

   The trend assumptions above vary according to the anticipated leveraging impact of deductibles and fixed copays.

2. The interest rate used to accumulate past values and discount future values is 3.57%.

3. The filed premium increase is 9.7% effective 5/1/ 2012. Rate increases are capped at 29.9% after the effects of aging and subscriber adjustment factors.

4. The assumed premium increases from 2013 and going forward are 13.9%. The assumed premium increases in the projection period 2013-2025 are assumed to be equal to the claims trend for the purposes of the lifetime loss ratio calculation.

5. The assumed claims durational curve based on Anthem's historical data is:

Length of Time in Plan	Claims Durational Factors
quarter 1	0.703
quarter 2	0.830
quarter 3	0.907
quarter 4	0.957
year 2 *	1.000
year 3	1.051
year 4	1.120
year 5	1.206
year 6	1.321
year 7	1.462
year 8	1.622
year 9	1.789
year 10	1.947
year 11+	2.033

*note: year 2 is set by convention to be one.

6. The assumed premium durational curve based on Anthem's historical data is:

Length of Time in Plan	Premium Durational Factors
quarter 1	0.935
quarter 2	0.956
quarter 3	0.969
quarter 4	0.983
year 2 *	1.000
year 3	1.025
year 4	1.060
year 5	1.106
year 6	1.163
year 7	1.229
year 8	1.301
year 9	1.377
year 10	1.449
year 11+	1.513

*note: year 2 is set by convention to be one.

7. Subscribers will experience the rate increase on their assigned renewal month. The assumed distribution of renewal months is:

Month	% Renewing
May-12	68.3%
Jun-12	10.1%
Jul-12	9.8%
Aug-12	11.9%
Sep-12	0.0%
Oct-12	0.0%
Nov-12	0.0%
Dec-12	0.0%
Jan-13	0.0%
Feb-13	0.0%
Mar-13	0.0%
Apr-13	0.0%
May-13	0.0%
Jun-13	0.0%

For Open forms, we are assuming that members' renewal dates will be adjusted to the latest of 1) May 2012 and 2) end of initial rate guarantee period.

Due to the fact that Open forms have not experienced a rate increase since the effective date of 9/23/2010, members sold in the period between 9/23/2010 and 4/30/2011 will have a renewal date of May 1, 2012.

8. Other Claims Impacts
The following claims impacts are assumed in the lifetime loss ratio calculation:

- Additional Autism Benefits effective on July 1, 2012:
In accordance with Senate Bill 946, chaptered 10/09/2011, we will be providing coverage for behavioral health treatment for pervasive developmental disorder or autism. We will add these benefits for all forms in this filing on July 1, 2012 as required.

- Maternity Benefits effective on July 1, 2012:
In accordance with Senate Bill 222, chaptered 10/06/2011, all forms will provide coverage for maternity services. We will add these benefits for all forms in this filing on July 1, 2012 as required.

Benefit Change	Impact to Claims PMPM
Autism Benefits	0.6%
Maternity Benefits	5.0%

Methodology

Lifetime Loss Ratio = C / P

Let i = the month of past (historical) or projected PMPM experience.

$$C = \sum_{i=1}^{\infty} \text{FV}(\text{Past Claims PMPM}_i \times \text{Membership}_i) + \sum_{i=1}^{\infty} \text{PV}(\text{Projected Claims PMPM}_i \times \text{Membership}_i)$$

$$P = \sum_{i=1}^{\infty} \text{FV}(\text{Past Premium PMPM}_i \times \text{Membership}_i) + \sum_{i=1}^{\infty} \text{PV}(\text{Projected Premium PMPM}_i \times \text{Membership}_i)$$

Where FV means the accumulated value and PV means the present values.

Future Lifetime Loss Ratio = FC / FP

Let i = the month of past (historical) or projected PMPM experience.

$$FC = \sum_{i=1}^{\infty} \text{PV}(\text{Projected Claims PMPM}_i \times \text{Membership}_i)$$

$$FP = \sum_{i=1}^{\infty} \text{PV}(\text{Projected Premium PMPM}_i \times \text{Membership}_i)$$

Where PV means the present values.

Policies sold on or after 7/1/2007 or policies that experience a rate revision on or after 7/1/2007 are subject to the 70% lifetime loss ratio standard.

For the purposes of calculating the values over the lifetime of the policy, future values are discounted to May 1, 2012 for Non-Grandfathered Open and past values are accumulated to May 1, 2012. Note that the calculation ends with projected claims data through 12/31/2025.

Historical and Projected Experience

The following is the historical and projected experience by year for the forms included in this filing. Months through June 2011 are historical data, with incurred claims paid though August 31, 2011. Months July 2011 and later are projected.

Policies subject to 70% Loss Ratio Standard (sold or received a rate revision on or after 7/1/07)

A. Non-Grandfathered Closed

	Member Months	Premium PMPM	Claims PMPM	MLR
1999	0	N/A	N/A	N/A
2000	0	N/A	N/A	N/A
2001	0	N/A	N/A	N/A
2002	0	N/A	N/A	N/A
2003	0	N/A	N/A	N/A
2004	0	N/A	N/A	N/A
2005	0	N/A	N/A	N/A
2006	0	N/A	N/A	N/A
2007	0	N/A	N/A	N/A
2008	0	N/A	N/A	N/A
2009	0	N/A	N/A	N/A
2010	129,924	$145	$87	60.5%
2011	1,041,602	$150	$123	81.6%
2012	722,156	$184	$141	76.8%
2013	524,261	$211	$171	80.9%
2014	384,880	$249	$207	83.1%
2015	286,626	$297	$255	85.9%
2016	220,652	$356	$319	89.6%
2017	174,272	$429	$402	93.7%
2018	138,258	$516	$504	97.7%
2019	110,029	$620	$626	101.0%
2020	87,850	$741	$759	102.4%
2021	70,378	$863	$885	102.5%
2022	56,576	$986	$1,013	102.7%
2023	45,643	$1,126	$1,159	102.9%
2024	36,955	$1,287	$1,328	103.1%
2025	30,029	$1,472	$1,522	103.3%
			Future Lifetime Loss Ratio:	91.9%
			Total Lifetime Loss Ratio:	88.4%

Note: Non-system claims adjustments of $0.22 PMPM, which tie with Anthem's financial records, are included in the future projection but are not included in June 2011 and prior.

B. Non-Grandfathered Open

	Member Months	Premium PMPM	Claims PMPM	MLR
1999	0	N/A	N/A	N/A
2000	0	N/A	N/A	N/A
2001	0	N/A	N/A	N/A
2002	0	N/A	N/A	N/A
2003	0	N/A	N/A	N/A
2004	0	N/A	N/A	N/A
2005	0	N/A	N/A	N/A
2006	0	N/A	N/A	N/A
2007	0	N/A	N/A	N/A
2008	0	N/A	N/A	N/A
2009	0	N/A	N/A	N/A
2010	250	$148	$18	11.9%
2011	1,095,297	$168	$105	62.7%
2012	2,542,879	$173	$127	73.2%
2013	3,147,048	$190	$152	79.9%
2014	3,498,452	$215	$176	81.7%
2015	3,733,434	$246	$204	83.0%
2016	3,893,129	$282	$237	84.1%
2017	4,009,208	$323	$275	85.1%
2018	4,096,608	$370	$318	86.0%
2019	4,160,871	$424	$368	86.7%
2020	4,207,851	$486	$425	87.4%
2021	4,242,299	$555	$488	87.9%
2022	4,267,650	$635	$560	88.3%
2023	4,286,381	$724	$642	88.6%
2024	4,300,280	$826	$734	88.8%
2025	4,310,641	$942	$839	89.0%
			Future Lifetime Loss Ratio:	86.6%
			Total Lifetime Loss Ratio:	86.2%

Note: Non-system claims adjustments of $0.22 PMPM, which tie with Anthem's financial records, are included in the future projection but are not included in June 2011 and prior.

6. Projected Federal Medical Loss Ratio for Calendar Year 2012

The Regulatory standard for pricing hospital, medical, and surgical policies set forth in Title 10, California Code of Regulations, Section 2222.12 requires insurers to demonstrate compliance with the 80% medical loss ratio federal standard on a market-segment basis at the time of rate review. We show expected medical loss ratios for Calendar Year 2012 based on definitions provided in 45 Code of Federal Regulations Part 158.

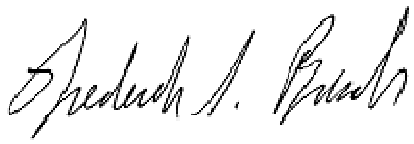
As this regulation requires compliance at the market-segment basis, medical loss ratios in the following table include all products regulated by the California Department of Insurance, including those not included in this filing (Grandfathered forms, HIPAA, Conversion, and Short Term).

This projection includes the estimated impact of an active life reserve – established for our Open Non-Grandfathered forms required by the Department as part of the prior rate filing (#PF-2010-01534) for these policy forms. The reserve is being established using 1 Year Preliminary Term methodology and result in a reserve amount of ~7.8M, or 0.55% increase to the overall loss ratio for 2012.

	Anthem BCL&H Total				HCR
Month	Member Months	Premium PMPM	Claims PMPM	Unadjusted MLR	Adjusted MLR
Jan-12	586,076	$195	$121	62.1%	66.0%
Feb-12	582,557	$195	$125	64.1%	68.0%
Mar-12	585,515	$195	$143	73.6%	77.9%
Apr-12	584,303	$195	$143	73.5%	77.8%
May-12	584,294	$209	$155	74.0%	78.3%
Jun-12	582,526	$210	$161	76.7%	81.0%
Jul-12	579,661	$212	$166	78.4%	82.8%
Aug-12	577,007	$212	$162	76.6%	80.9%
Sep-12	573,255	$213	$168	79.0%	83.4%
Oct-12	569,868	$213	$181	85.0%	89.6%
Nov-12	566,375	$213	$181	85.1%	89.7%
Dec-12	562,774	$213	$198	92.8%	97.7%
CY 2012	6,934,208	$206	$158	76.9%	81.24%

7. Certification

I, Frederick Busch, am an actuary for Anthem Blue Cross Life and Health Insurance Company and a member of the American Academy of Actuaries. I meet the qualification standards of the American Academy of Actuaries for rate filings of health plans. I have prepared this actuarial memorandum to be consistent with Actuarial Standard of Practice Number 8 as adopted by the Actuarial Standards Board. I certify that, to the best of my knowledge, this filing is in compliance with the laws and regulations of the State of California with regard to development of premium rates. In particular and in accordance with Title 10, California Code of Regulations, Section 2222.12 ("Standards of Reasonability"), in my opinion the benefits are reasonable in relation to the premiums for the individual plans subject to the Rate Filing, the lifetime and future projected loss ratios are anticipated to exceed the 70% minimum requirement, and 2012 projected federal standard loss ratios are above the 80% minimum requirement.



Frederick Busch, F.S.A., M.A.A.A.
Staff VP & Actuary
Anthem Blue Cross Life and Health Insurance Company
November 30, 2011

Anthem Blue Cross Life and Health Insurance Company
Individual Rates effective July 1, 2012
Closed Non-Grandfathered Health Plans: Medical Trend Analysis

Product	Unleveraged Trend Factor[1]	Product Leverage Factor	Composite Medical Trend w/ Product Leverage
	(1)	(2)	(3) = (1) x (2)
SmartSense		1.17	13.2%
Right Plan		1.09	12.3%
Tonik		1.17	13.2%
Lumenos w/ Maternity		1.26	14.2%
Lumenos w/o Maternity	11.3%	1.26	14.2%
Individual PPO Plans		1.27	14.3%
PPO Share		1.28	14.4%
PPO Saver		1.14	12.9%
Basic Hospital Plans		1.15	13.0%
ClearProtection		1.24	14.0%
CoreGuard		1.31	14.7%
Premier		1.20	13.5%

(1) Unleverage Trend Factor from Trend Analysis for corresponding Grandfathered Products

Anthem Blue Cross Life and Health Insurance Company
Individual Rates effective May 1, 2012
Open Non-Grandfathered Health Plans: Medical Trend Analysis

Product	Unleveraged Trend Factor[1]	Product Leverage Factor	Composite Medical Trend w/ Product Leverage
	(1)	(2)	(3) = (1) x (2)
SmartSense PLUS		1.23	13.8%
Tonik PLUS		1.23	13.9%
Lumenos w/ Mat PLUS		1.28	14.4%
Lumenos w/o Mat PLUS	11.3%	1.25	14.1%
PPO Share PLUS		1.17	13.2%
ClearProtection PLUS		1.21	13.7%
CoreGuard PLUS		1.31	14.7%
Premier PLUS		1.24	14.0%

(1) Unleverage Trend Factor from Trend Analysis for corresponding Grandfathered Products

Anthem Blue Cross Life and Health Insurance Company
Individual Rates effective July 1, 2012
Closed Non-Grandfathered Health Plans

Durational Factors - Medical Loss Ratios

Duration	Smart-Sense	Basic Hospital	PPO Share	Individual PPO Plans	Right Plan	Tonik	Lumenos w/o Mat	PPO Saver	Lumenos w/Mat	Clear Protection	Core-Guard	Premier
Quarter 1	76.5%	64.9%	63.7%	63.3%	76.5%	77.6%	63.3%	76.5%	63.7%	76.5%	76.5%	76.5%
Quarter 2	89.0%	70.7%	88.5%	67.8%	89.0%	89.5%	67.8%	89.0%	88.5%	89.0%	89.0%	89.0%
Quarter 3	95.5%	80.6%	99.4%	76.4%	95.5%	95.6%	76.4%	95.5%	99.4%	95.5%	95.5%	95.5%
Quarter 4	98.5%	91.2%	102.1%	87.6%	98.5%	98.6%	87.6%	98.5%	102.1%	98.5%	98.5%	98.5%
Year 2[(1)]	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Year 3	101.3%	102.0%	95.6%	112.5%	101.3%	101.3%	112.5%	101.3%	95.6%	101.3%	101.3%	101.3%
Year 4	103.3%	103.1%	91.3%	124.5%	103.3%	103.4%	124.5%	103.3%	91.3%	103.3%	103.3%	103.3%
Year 5	106.6%	103.9%	88.6%	127.8%	106.6%	106.8%	127.8%	106.6%	88.6%	106.6%	106.6%	106.6%
Year 6	111.2%	104.6%	88.4%	132.0%	111.2%	111.4%	132.0%	111.2%	88.4%	111.2%	111.2%	111.2%
Year 7	116.6%	105.1%	90.6%	136.9%	116.6%	116.9%	136.9%	116.6%	90.6%	116.6%	116.6%	116.6%
Year 8	122.4%	105.5%	94.1%	141.5%	122.4%	122.8%	141.5%	122.4%	94.1%	122.4%	122.4%	122.4%
Year 9	128.0%	105.9%	97.6%	145.4%	128.0%	128.5%	145.4%	128.0%	97.6%	128.0%	128.0%	128.0%
Year 10	132.6%	106.2%	99.6%	148.0%	132.6%	133.3%	148.0%	132.6%	99.6%	132.6%	132.6%	132.6%
Year 11+	132.6%	106.2%	99.6%	148.0%	132.6%	133.5%	148.0%	132.6%	99.6%	132.6%	132.6%	132.6%

[(1)] Note: Anthem sets Year 2 equal to 100% by convention

Anthem Blue Cross Life and Health Insurance Company
Individual Rates effective May 1, 2012
Open Non-Grandfathered Health Plans

Durational Factors - Medical Loss Ratios

Duration	Smart-Sense PLUS	PPO Share PLUS	Tonik PLUS	Lumenos w/o Mat PLUS	Lumenos w/Mat PLUS	Clear Protection PLUS	Core-Guard PLUS	Premier PLUS
Quarter 1	76.5%	63.7%	78.4%	63.3%	63.7%	76.5%	76.5%	76.5%
Quarter 2	89.0%	88.5%	89.9%	67.8%	88.5%	89.0%	89.0%	89.0%
Quarter 3	95.5%	99.4%	95.9%	76.4%	99.4%	95.5%	95.5%	95.5%
Quarter 4	98.5%	102.1%	98.6%	87.6%	102.1%	98.5%	98.5%	98.5%
Year 2[(1)]	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Year 3	101.3%	95.6%	101.2%	112.5%	95.6%	101.3%	101.3%	101.3%
Year 4	103.3%	91.3%	103.1%	124.5%	91.3%	103.3%	103.3%	103.3%
Year 5	106.6%	88.6%	106.2%	127.8%	88.6%	106.6%	106.6%	106.6%
Year 6	111.2%	88.4%	110.5%	132.0%	88.4%	111.2%	111.2%	111.2%
Year 7	116.6%	90.6%	115.7%	136.9%	90.6%	116.6%	116.6%	116.6%
Year 8	122.4%	94.1%	121.3%	141.5%	94.1%	122.4%	122.4%	122.4%
Year 9	128.0%	97.6%	126.6%	145.4%	97.6%	128.0%	128.0%	128.0%
Year 10	132.6%	99.6%	131.1%	148.0%	99.6%	132.6%	132.6%	132.6%
Year 11+	132.6%	99.6%	131.2%	148.0%	99.6%	132.6%	132.6%	132.6%

[(1)] Note: Anthem sets Year 2 equal to 100% by convention

Attachment 11(a)

Anthem Blue Cross Life and Health Insurance Company
Individual Rates effective July 1, 2012
Closed Non-Grandfathered Health Plans

Seasonality Factors

Month	Smart-Sense	Basic Hospital	PPO Share	Individual PPO Plans	Right Plan	Tonik	Lumenos w/o Mat	PPO Saver	Lumenos w/Mat	Clear Protection	Core-Guard	Premier
Jan	0.80	1.00	0.80	0.81	1.00	0.81	0.81	0.79	0.81	0.79	0.79	0.79
Feb	0.82	1.00	0.82	0.81	1.00	0.83	0.81	0.82	0.81	0.82	0.82	0.82
Mar	0.97	1.00	0.97	0.89	1.00	0.97	0.89	0.97	0.89	0.97	0.97	0.97
Apr	0.93	1.00	0.93	0.95	1.00	0.94	0.95	0.94	0.95	0.94	0.94	0.94
May	0.99	1.00	0.99	1.13	1.00	0.99	1.13	0.98	1.13	0.98	0.98	0.98
Jun	1.04	1.00	1.04	1.03	1.00	1.04	1.03	1.05	1.03	1.05	1.05	1.05
Jul	1.05	1.00	1.05	1.01	1.00	1.05	1.01	1.06	1.01	1.06	1.06	1.06
Aug	1.03	1.00	1.03	0.87	1.00	1.03	0.87	1.04	0.87	1.04	1.04	1.04
Sep	1.01	1.00	1.01	1.04	1.00	1.01	1.04	1.01	1.04	1.01	1.01	1.01
Oct	1.10	1.00	1.10	1.11	1.00	1.09	1.11	1.09	1.11	1.09	1.09	1.09
Nov	1.10	1.00	1.10	1.04	1.00	1.09	1.04	1.09	1.04	1.09	1.09	1.09
Dec	1.15	1.00	1.15	1.31	1.00	1.14	1.31	1.15	1.31	1.15	1.15	1.15

Anthem Blue Cross Life and Health Insurance Company
Individual Rates effective May 1, 2012
Open Non-Grandfathered Health Plans

Seasonality Factors

Month	Smart-Sense PLUS	PPO Share PLUS	Tonik PLUS	Lumenos w/o Mat PLUS	Lumenos w/Mat PLUS	Clear Protection PLUS	Core-Guard PLUS	Premier PLUS
Jan	0.79	0.80	0.80	0.81	0.81	0.79	0.79	0.79
Feb	0.82	0.82	0.83	0.81	0.81	0.82	0.82	0.82
Mar	0.97	0.97	0.98	0.89	0.89	0.97	0.97	0.97
Apr	0.94	0.93	0.94	0.95	0.95	0.94	0.94	0.94
May	0.98	0.99	0.99	1.13	1.13	0.98	0.98	0.98
Jun	1.05	1.04	1.05	1.03	1.03	1.05	1.05	1.05
Jul	1.06	1.05	1.06	1.01	1.01	1.06	1.06	1.06
Aug	1.04	1.03	1.04	0.87	0.87	1.04	1.04	1.04
Sep	1.01	1.01	1.01	1.04	1.04	1.01	1.01	1.01
Oct	1.09	1.10	1.08	1.11	1.11	1.09	1.09	1.09
Nov	1.09	1.10	1.08	1.04	1.04	1.09	1.09	1.09
Dec	1.15	1.15	1.14	1.31	1.31	1.15	1.15	1.15

Attachment 12(a)

Anthem Blue Cross Life and Health Insurance Company
Individual Rates effective July 1, 2012
Non-Grandfathered Closed Health Plans

Benefit Changes

	Prior Filed Benefit Changes						
Product	ACA-mandated benefits[1]	Other Changes Eff 1/1/2012[2]	Maternity Eff 7/1/2012[3]	Autism Eff 7/1/2012	Gross Impact	Exper Period Impact	Rating Period Impact
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
SmartSense	10.4%	(4.1%)	2.0%	0.6%	8.7%	8.9%	(0.2%)
Basic Hospital	11.4%	0.0%	2.0%	0.6%	14.3%	9.1%	4.7%
PPO Share	5.6%	(5.7%)	(2.5%)	0.6%	(2.4%)	4.7%	(6.8%)
Individual PPO Plans	10.9%	(6.3%)	2.0%	0.6%	6.6%	9.0%	(2.2%)
Right Plan	5.6%	(2.7%)	2.0%	0.6%	5.4%	4.8%	0.6%
Tonik w/Dental & Vision	5.8%	(4.3%)	2.0%	0.6%	3.9%	4.7%	(0.7%)
Lumenos w/o Maternity	2.6%	(6.4%)	2.0%	0.6%	(1.5%)	2.2%	(3.6%)
PPO Saver	11.4%	0.0%	2.0%	0.6%	14.3%	10.0%	3.9%
Lumenos w/ Maternity	2.6%	(6.3%)	(2.5%)	0.6%	(5.8%)	2.3%	(7.9%)
ClearProtection	10.4%	0.0%	2.0%	0.6%	13.3%	9.2%	3.8%
CoreGuard	10.4%	0.0%	2.0%	0.6%	13.3%	8.2%	4.8%
Premier	7.3%	0.0%	2.0%	0.6%	10.1%	3.8%	6.1%

[1] Impact of ACA-mandated Benefit Changes previously filed (2011 filing #PF-2011-00002)

[2] Benefit Changes previously filed excluding assumed change in Generic Rx Formulary (2011 filing #PF-2011-00002)

[3] Maternity cost assumed to grade in over 3-months from effective date

Attachment 12(b)

Anthem Blue Cross Life and Health Insurance Company
Individual Rates effective May 1, 2012
Non-Grandfathered Open Health Plans

Benefit Changes

	Prior Filed Benefit Changes						
Product	ACA-mandated benefits[1]	Other Changes Eff 1/1/2012[2]	Maternity Eff 7/1/2012[3]	Autism Eff 7/1/2012	Gross Impact	Exper Period Impact	Rating Period Impact
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
SmartSense Plus	0.0%	0.0%	5.0%	0.6%	5.6%	0.0%	5.6%
PPO Share (New)	0.0%	0.0%	(2.5%)	0.6%	(1.9%)	0.0%	(1.9%)
Tonik (New) w/Den & Vis	0.0%	0.0%	5.0%	0.6%	5.6%	0.0%	5.6%
Lumenos Plus w/o Mat	0.0%	0.0%	5.0%	0.6%	5.6%	0.0%	5.6%
Lumenos Plus w/ Mat	0.0%	0.0%	(2.5%)	0.6%	(1.9%)	0.0%	(1.9%)
ClearProtection PLUS	0.0%	0.0%	5.0%	0.6%	5.6%	0.0%	5.6%
CoreGuard PLUS	0.0%	0.0%	5.0%	0.6%	5.6%	0.0%	5.6%
Premier PLUS	0.0%	0.0%	5.0%	0.6%	5.6%	0.0%	5.6%

[1] Impact reflected since inception

[2] Benefit Changes previously filed excluding assumed change in Generic Rx Formulary (2011 filing #PF-2011-00002)

[3] Maternity cost assumed to grade in over 3-months from effective date

Anthem Blue Cross Life and Health Insurance Company
Individual Rates effective May 1, 2012 and July 1, 2012
Non-Grandfathered Health Plans

Monthly Lapse Rates

Monthly Lapse Rates			
Duration	BASIC	Standard PPO	High Ded PPO
1	0.20%	0.14%	0.10%
2	5.89%	3.90%	3.05%
3	5.31%	3.82%	3.02%
4	4.97%	3.77%	2.99%
5	4.73%	3.74%	2.97%
6	4.54%	3.71%	2.94%
7	4.39%	3.69%	2.92%
8	4.26%	3.67%	2.89%
9	4.15%	3.66%	2.86%
10	4.05%	3.65%	2.84%
11	3.96%	3.63%	2.81%
12	3.88%	3.62%	2.79%
13	3.81%	3.61%	2.76%
14	3.74%	3.60%	2.74%
15	3.68%	3.60%	2.71%
16	3.62%	3.59%	2.69%
17	3.57%	3.58%	2.67%
18	3.52%	3.57%	2.64%
19	3.47%	3.57%	2.62%
20	3.42%	3.56%	2.59%
21	3.38%	3.56%	2.57%
22	3.34%	3.55%	2.55%
23	3.30%	3.54%	2.52%
24	3.26%	3.54%	2.50%
25	3.23%	3.53%	2.48%
26	3.19%	3.53%	2.45%
27	3.16%	3.53%	2.43%
28	3.13%	3.52%	2.41%
29	3.10%	3.52%	2.38%
30	3.07%	3.51%	2.36%
31	3.04%	3.51%	2.34%
32	3.01%	3.51%	2.32%
33	2.99%	3.50%	2.29%
34	2.96%	3.50%	2.27%
35	2.93%	3.49%	2.25%
36	2.91%	3.49%	2.23%
37	2.89%	3.49%	2.21%
38	2.86%	3.49%	2.18%
39	2.84%	3.48%	2.16%
40	2.82%	3.48%	2.14%

NOTE	
BASIC =	Basic Hospital Plans
Standard PPO =	SmartSense, PPO Share, Right Plan, Tonik, Lumenos w/ Maternity, PPO Saver, Premium, ClearProtection, and CoreGuard
High Ded PPO =	Individual PPO Plans & Lumenos w/o Maternity

Anthem Blue Cross Life and Health Insurance Company
Individual Rates effective May 1, 2012 and July 1, 2012
Non-Grandfathered Health Plans

Monthly Lapse Rates

Monthly Lapse Rates			
Duration	BASIC	Standard PPO	High Ded PPO
41	2.80%	3.48%	2.12%
42	2.78%	3.47%	2.10%
43	2.76%	3.47%	2.08%
44	2.74%	3.47%	2.06%
45	2.72%	3.47%	2.04%
46	2.70%	3.46%	2.02%
47	2.68%	3.46%	2.00%
48	2.66%	3.46%	1.98%
49	2.64%	3.46%	1.96%
50	2.63%	3.45%	1.94%
51	2.61%	3.45%	1.92%
52	2.59%	3.45%	1.90%
53	2.58%	3.45%	1.88%
54	2.56%	3.44%	1.86%
55	2.55%	3.44%	1.84%
56	2.53%	3.44%	1.82%
57	2.52%	3.43%	1.80%
58	2.50%	3.40%	1.78%
59	2.49%	3.37%	1.76%
60	2.47%	3.34%	1.74%
61	2.46%	3.30%	1.73%
62	2.44%	3.26%	1.71%
63	2.43%	3.23%	1.69%
64	2.42%	3.19%	1.67%
65	2.40%	3.15%	1.65%
66	2.39%	3.11%	1.63%
67	2.38%	3.07%	1.62%
68	2.37%	3.02%	1.60%
69	2.35%	2.98%	1.58%
70	2.34%	2.93%	1.56%
71	2.33%	2.89%	1.55%
72	2.32%	2.84%	1.53%
>=73	2.30%	2.77%	1.51%

Anthem Blue Cross Life & Health Ins Co.; Rate Filing for Non-Grandfathered Products; Effective 5/2012 and 7/2012

RATE DEVELOPMENT PROCESS

(1) Shaded Cells not 100% credible; see Actuarial Modeling Report for details

Plan Name Prefix: "C" = Closed; "O" = Open

Base Period: 07/01/2010 - 06/30/2011 Rating Period: 05/01/2012 - 05/31/2014	C-Individual PPO Plans	C-Basic Hospital Plans	C-Lumenos w/Maternity	C-Lumenos w/o Maternity	C-Clear Protection	C-CoreGuard
BASE PERIOD ANALYSIS						
1. Member Months	55,460	25,173	18,325	46,159	103,989	14,973
2. Actual Premium	$6,647,659	$3,241,004	$2,360,812	$6,929,873	$12,294,410	$2,082,657
3. Estimated Incurred Claims	$3,821,050	$1,292,584	$6,084,863	$4,441,907	$7,261,620	$1,143,564
4. Current Loss Ratio	57.5%	39.9%	257.7%	64.1%	59.1%	54.9%
5. Current Claims PMPM	$68.90	$51.35	$332.05	$96.23	$69.83	$76.38
6. Credibility Adjusted Claims PMPM(1)	$69.20	$57.51	$331.01	$95.10	$69.83	$96.21
7. Midpoint of Base Period	3/14/2011	3/12/2011	3/14/2011	3/14/2011	3/13/2011	3/13/2011
PREMIUM AT CURRENT RATES						
8. Prem at Current Rates PMPM	$151.05	$125.93	$173.09	$174.07	$132.35	$168.00
MEDICAL TREND ANALYSIS						
9. Annual Claims Trend	14.3%	13.0%	14.2%	14.2%	14.0%	14.7%
10. Initial Rate Change Date	7/1/2012	7/1/2012	7/1/2012	7/1/2012	7/1/2012	7/1/2012
11. Midpoint of Rating Period	1/11/2013	12/22/2012	12/20/2012	12/24/2012	1/4/2013	12/20/2012
12. Months of Trend	21.98	21.40	21.27	21.38	21.79	21.31
13. Cumulative Trend	27.7%	24.3%	26.5%	26.7%	26.9%	27.6%
RATING PERIOD CLAIMS COST						
14. Change in Plan Mix Factor (Claims)	(0.8%)	(0.6%)	(1.1%)	(0.7%)	(0.8%)	(0.8%)
15. Change in Clms Duration Factor	56.9%	27.5%	(6.5%)	57.6%	10.7%	11.1%
16. Change in Seasonality Factor	2.7%	0.0%	4.2%	4.8%	5.6%	3.6%
17. Benefit changes: ACA and "Other"	(2.2%)	4.7%	(7.9%)	(3.6%)	3.8%	4.8%
18. Rating Period Claims PMPM	$138.27	$94.91	$371.79	$190.51	$106.67	$146.82
RATING PERIOD PREMIUMS						
19. Change in Plan Mix Factor (Prem)	(0.9%)	(0.7%)	(1.7%)	(0.7%)	(0.8%)	(0.7%)
20. Change in Prem Duration Factor	13.5%	6.3%	(3.5%)	13.2%	5.1%	4.8%
21. Adj'd Prem at Current Rates PMPM	$169.94	$132.95	$164.14	$195.62	$137.93	$174.83
22. Target Loss Ratio	72.9%	81.1%	79.3%	72.5%	75.4%	75.3%
23. Required Premium PMPM	$189.74	$117.08	$469.09	$262.85	$141.54	$194.92
24. Required Rate Increase - new business	11.7%	(11.9%)	185.8%	34.4%	2.6%	11.5%
25. Proposed Rate Increase - new business	9.6%	(0.4%)	9.8%	9.5%	9.8%	9.4%
26. Renewal Rate Change	9.6%	(0.4%)	9.8%	9.5%	9.8%	9.4%

Anthem Blue Cross Life & Health Ins Co.; Rate Filing for Non-Grandfathered Products; Effective 5/2012 and 7/2012

RATE DEVELOPMENT PROCESS

(1) Shaded Cells not 100% credible; see Actuarial Modeling Report for details

Plan Name Prefix: "C" = Closed; "O" = Open

Base Period: 07/01/2010 - 06/30/2011 Rating Period: 05/01/2012 - 05/31/2014	C-PPO Share	C-Premium	C-RightPlan	C-PPO Saver	C-Smart Sense	C-Tonik
BASE PERIOD ANALYSIS						
1. Member Months	25,123	47,042	20,006	5,123	313,565	29,416
2. Actual Premium	$5,259,886	$8,936,778	$4,174,221	$885,572	$41,480,801	$4,047,442
3. Estimated Incurred Claims	$6,085,583	$5,311,012	$3,052,013	$825,062	$31,805,401	$3,144,510
4. Current Loss Ratio	115.7%	59.4%	73.1%	93.2%	76.7%	77.7%
5. Current Claims PMPM	$242.23	$112.90	$152.55	$161.07	$101.43	$106.90
6. Credibility Adjusted Claims PMPM(1)	$243.80	$111.46	$153.07	$141.85	$101.43	$110.48
7. Midpoint of Base Period	3/14/2011	1/4/2011	3/13/2011	3/13/2011	3/13/2011	3/12/2011
PREMIUM AT CURRENT RATES						
8. Prem at Current Rates PMPM	$269.09	$218.01	$271.34	$225.09	$172.40	$174.44
MEDICAL TREND ANALYSIS						
9. Annual Claims Trend	14.4%	13.5%	12.3%	12.9%	13.2%	13.2%
10. Initial Rate Change Date	7/1/2012	7/1/2012	7/1/2012	7/1/2012	7/1/2012	7/1/2012
11. Midpoint of Rating Period	12/20/2012	12/20/2012	12/20/2012	12/20/2012	12/23/2012	12/20/2012
12. Months of Trend	21.28	23.53	21.31	21.30	21.39	21.35
13. Cumulative Trend	26.9%	28.2%	22.9%	24.0%	24.7%	24.7%
RATING PERIOD CLAIMS COST						
14. Change in Plan Mix Factor (Claims)	(0.6%)	(0.6%)	(0.7%)	(0.7%)	(0.8%)	(0.7%)
15. Change in Clms Duration Factor	(6.5%)	19.1%	10.7%	9.0%	10.8%	10.8%
16. Change in Seasonality Factor	4.6%	3.0%	0.0%	2.7%	5.6%	5.1%
17. Benefit changes: ACA and "Other"	(6.8%)	6.1%	0.6%	3.9%	(0.2%)	(0.7%)
18. Rating Period Claims PMPM	$280.36	$184.78	$207.99	$203.09	$146.50	$158.26
RATING PERIOD PREMIUMS						
19. Change in Plan Mix Factor (Prem)	(0.5%)	(0.5%)	(0.7%)	(0.7%)	(0.9%)	(0.7%)
20. Change in Prem Duration Factor	(3.4%)	6.2%	4.9%	4.9%	4.9%	4.5%
21. Adj'd Prem at Current Rates PMPM	$258.62	$230.45	$282.54	$234.34	$179.23	$180.96
22. Target Loss Ratio	79.2%	75.2%	75.4%	75.3%	75.3%	75.3%
23. Required Premium PMPM	$353.84	$245.56	$276.02	$269.55	$194.52	$210.13
24. Required Rate Increase - new business	36.8%	6.6%	(2.3%)	15.0%	8.5%	16.1%
25. Proposed Rate Increase - new business	9.9%	3.2%	9.7%	9.9%	9.9%	9.9%
26. Renewal Rate Change	9.9%	7.9%	9.7%	9.9%	9.9%	9.9%

Anthem Blue Cross Life & Health Ins Co.; Rate Filing for Non-Grandfathered Products; Effective 5/2012 and 7/2012

RATE DEVELOPMENT PROCESS

(1) Shaded Cells not 100% credible; see Actuarial Modeling Report for details

Plan Name Prefix: "C" = Closed; "O" = Open

Base Period: 07/01/2010 - 06/30/2011 Rating Period: 05/01/2012 - 05/31/2014	O-Lumenos w/MaternityPLUS	O-Lumenos w/o MaternityPLUS	O-Clear ProtectionPLUS	O-Core GuardPLUS	O-PPO SharePLUS
BASE PERIOD ANALYSIS					
1. Member Months	647	10,847	107,024	8,658	259
2. Actual Premium	$234,267	$2,362,607	$13,153,853	$1,316,546	$146,318
3. Estimated Incurred Claims	$75,347	$2,178,404	$8,119,894	$578,113	$59,260
4. Current Loss Ratio	32.2%	92.2%	61.7%	43.9%	40.5%
5. Current Claims PMPM	$116.47	$200.83	$75.87	$66.78	$228.70
6. Credibility Adjusted Claims PMPM(1)	$215.81	$127.75	$75.87	$69.74	$212.92
7. Midpoint of Base Period	4/30/2011	5/12/2011	5/12/2011	5/12/2011	4/28/2011
PREMIUM AT CURRENT RATES					
8. Prem at Current Rates PMPM	$358.81	$225.00	$124.76	$155.78	$532.15
MEDICAL TREND ANALYSIS					
9. Annual Claims Trend	14.4%	14.1%	13.7%	14.7%	13.2%
10. Initial Rate Change Date	5/1/2012	5/1/2012	5/1/2012	5/1/2012	5/1/2012
11. Midpoint of Rating Period	3/2/2013	3/3/2013	3/11/2013	2/24/2013	12/7/2012
12. Months of Trend	22.07	21.73	21.98	21.49	19.33
13. Cumulative Trend	28.1%	27.0%	26.5%	27.8%	22.1%
RATING PERIOD CLAIMS COST					
14. Change in Plan Mix Factor (Claims)	0.0%	(3.0%)	(1.4%)	(1.6%)	(0.8%)
15. Change in Clms Duration Factor	35.1%	50.0%	25.2%	26.4%	36.8%
16. Change in Seasonality Factor	(0.1%)	0.9%	0.4%	0.1%	1.0%
17. Benefit changes: ACA and "Other"	(1.9%)	5.6%	5.6%	5.6%	(1.9%)
18. Rating Period Claims PMPM	$365.86	$251.37	$125.73	$117.22	$349.53
RATING PERIOD PREMIUMS					
19. Change in Plan Mix Factor (Prem)	0.0%	(3.0%)	(1.0%)	(1.7%)	1.6%
20. Change in Prem Duration Factor	1.6%	7.6%	4.3%	4.5%	1.1%
21. Adj'd Prem at Current Rates PMPM	$364.40	$234.69	$128.74	$159.99	$546.52
22. Target Loss Ratio	77.1%	57.1%	70.1%	70.5%	80.4%
23. Required Premium PMPM	$474.41	$439.99	$179.42	$166.25	$434.77
24. Required Rate Increase - new business	30.2%	87.5%	39.4%	3.9%	(20.4%)
25. Proposed Rate Increase - new business	9.7%	9.7%	9.7%	9.7%	9.7%
26. Renewal Rate Change	9.7%	9.7%	9.7%	9.7%	9.7%

Anthem Blue Cross Life & Health Ins Co.; Rate Filing for Non-Grandfathered Products; Effective 5/2012 and 7/2012

RATE DEVELOPMENT PROCESS

(1) Shaded Cells not 100% credible; see Actuarial Modeling Report for details

Plan Name Prefix: "C" = Closed; "O" = Open

Base Period: 07/01/2010 - 06/30/2011 Rating Period: 05/01/2012 - 05/31/2014	O-PremiumPLUS	O-Smart SensePLUS	O-TonikPLUS	C-NGF Total	O-NGF Total	Grand Total
BASE PERIOD ANALYSIS						
1. Member Months	54,677	46,986	22,398	**704,354**	**251,496**	**955,851**
2. Actual Premium	$12,545,738	$8,601,876	$3,836,734	**$98,341,116**	**$42,197,940**	**$140,539,056**
3. Estimated Incurred Claims	$5,973,300	$3,918,888	$1,760,147	**$74,269,169**	**$22,663,352**	**$96,932,521**
4. Current Loss Ratio	47.6%	45.6%	45.9%	**75.5%**	**53.7%**	**69.0%**
5. Current Claims PMPM	$109.25	$83.41	$78.58	**$105.44**	**$90.11**	**$101.41**
6. Credibility Adjusted Claims PMPM(1)	$108.35	$83.25	$83.82	**$105.99**	**$87.55**	**$101.14**
7. Midpoint of Base Period	4/27/2011	5/12/2011	4/21/2011	**3/8/2011**	**5/7/2011**	**3/24/2011**
PREMIUM AT CURRENT RATES						
8. Prem at Current Rates PMPM	$236.31	$188.71	$167.20	**$172.95**	**$171.15**	**$172.48**
MEDICAL TREND ANALYSIS						
9. Annual Claims Trend	14.0%	13.8%	13.9%	**13.6%**	**13.9%**	**13.7%**
10. Initial Rate Change Date	5/1/2012	5/1/2012	5/1/2012	**7/1/2012**	**5/1/2012**	**N/A**
11. Midpoint of Rating Period	2/15/2013	2/28/2013	2/28/2013	**12/25/2012**	**3/1/2013**	**1/12/2013**
12. Months of Trend	21.66	21.59	22.30	**21.60**	**21.81**	**21.66**
13. Cumulative Trend	26.7%	26.2%	27.4%	**25.8%**	**26.6%**	**26.0%**
RATING PERIOD CLAIMS COST						
14. Change in Plan Mix Factor (Claims)	(1.5%)	(2.0%)	0.0%	**(0.9%)**	**(4.5%)**	**0.4%**
15. Change in Clms Duration Factor	24.0%	26.6%	19.5%	**14.4%**	**26.0%**	**8.6%**
16. Change in Seasonality Factor	2.4%	1.0%	3.5%	**4.5%**	**1.3%**	**3.6%**
17. Benefit changes: ACA and "Other"	5.6%	5.6%	5.6%	**(0.8%)**	**5.6%**	**0.7%**
18. Rating Period Claims PMPM	$181.32	$138.93	$139.54	**$156.76**	**$142.69**	**$144.97**
RATING PERIOD PREMIUMS						
19. Change in Plan Mix Factor (Prem)	(1.4%)	(2.4%)	0.0%	**(1.7%)**	**(6.5%)**	**(3.8%)**
20. Change in Prem Duration Factor	4.4%	4.5%	3.7%	**5.6%**	**4.4%**	**2.5%**
21. Adj'd Prem at Current Rates PMPM	$243.30	$192.39	$173.40	**$179.59**	**$167.01**	**$170.19**
22. Target Loss Ratio	70.8%	70.4%	70.7%	**75.4%**	**69.0%**	**70.0%**
23. Required Premium PMPM	$256.21	$197.37	$197.40	**$207.80**	**$206.82**	**$206.98**
24. Required Rate Increase - new business	5.3%	2.6%	13.8%	**15.7%**	**23.8%**	**21.6%**
25. Proposed Rate Increase - new business	9.7%	9.7%	9.7%	**9.2%**	**9.7%**	**9.6%**
26. Renewal Rate Change	9.7%	9.7%	9.7%	**9.4%**	**9.7%**	**9.6%**

Anthem Blue Cross Life and Health Insurance Company
Individual Rates effective May 1, 2012 and July 1, 2012
Non-Grandfathered Health Plans
Rate Change Distribution

% of Members[1]	Rate Change %[2]
2.4%	-25.4% - 0%
22.4%	0% - 4.9%
21.8%	5% - 9.9%
31.6%	10% - 14.9%
11.3%	15% - 19.9%
5.7%	20% - 24.9%
4.6%	25% - 29.8%
0.1%	>29.8%

Average Filed Rate Change: 9.6%

[1] Members as of August 2011

[2] Before Member "Aging"